

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 409 2-4-68 16501 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												16515							
1. DECEASED-NAME (Type or Print) Kenneth Eugene Adams						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 11 Day 10 Year 1968						2b. HOUR 6:45 AM							
3. SEX M		4. RACE N		5. DATE OF BIRTH Dec. 31, 1947		6. AGE (In years last birthday) 20 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month 11 Day 10 Year 1968		2d. HOUR 6 AM					
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Talbot Md.							
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Shipping Clerk				12b. KIND OF BUSINESS OR INDUSTRY None							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland						13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 23 S. Locust Street Easton, Md.							
14. FATHER'S NAME First William E. Middle Adams Last Adams						15. MOTHER'S MAIDEN NAME First Virginia Middle Adams Last (Nichols)													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16b. SOCIAL SECURITY NO. Mar. 66-Mar 68 216485038		17. INFORMANT RFD#2, ADDRESS 336 William Adams Federalburg, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of Gastric Content DUE TO, OR AS A CONSEQUENCE OF (c) Car accident														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hour 3 hour 3 hour					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8234 11/10/68																			
19a. DATE OF OPERATION 11/10/68						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DRIVER OF CAR-STRUCK CULVERT						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1P P.M. 11-10-68						21b. TIME OF INJURY Month, Day, Year 11-10-68						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) DRIVER OF CAR-STRUCK CULVERT							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HIGHWAY						21f. LOCATION Street or R.F.D. No. CORDOVA City or Town TALBOT County MD. State MD.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Louis S. Welty M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 10 Nov '68							
EXAMINER'S NAME (Type) Louis S. Welty						ADDRESS 426 Doyer Street, Easton, Md. 21601						23a. REC'D BY REGISTRAR NOV 14 1968				23b. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY Federalburg				23d. LOCATION (City or Town) (County) (State) Federalburg Caroline Md.							
24. FUNERAL DIRECTOR B. L. Dashiell						ADDRESS 426 Doyer Street, Easton, Md. 21601						25a. REC'D BY REGISTRAR NOV 14 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <u>Susie</u> First <u>Allen</u> Middle <u>Allen</u> Last						2a. DATE OF DEATH <u>11</u> Month <u>15</u> Day <u>68</u> Year			2b. HOUR <u>8:40</u> MIN			
3. SEX <u>Female</u>			4. RACE <u>Negro</u>			5. DATE OF BIRTH <u>June 5, 1903</u>			6. AGE (In years lost birthday) <u>65</u> YRS.			
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Talbot</u> Md.			
10. CITY OR TOWN OF DEATH <u>Easton</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Ret. Laborer</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>				13b. COUNTY <u>Talbot</u>		13c. CITY OR TOWN <u>St. Michaels</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>108 Talbot St.,</u>		
14. FATHER'S NAME First <u>Eli</u> Middle <u>Jones</u> Last						15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>Charles Allen, Jr., St. Michaels, Maryland</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrothorax, bilateral</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201 Diabetes mellitus</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>E.C.H. Schmidt</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <u>16 Nov 68</u>				
22d. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>								22e. ADDRESS <u>Easton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>Nov 18, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Sherwood, Maryland</u>			
24. FUNERAL DIRECTOR <u>Harrison E. Leonard</u> ADDRESS <u>St. Michaels, Md.</u>								25a. REC'D BY REGISTRAR <u>NO</u> DATE <u>20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) FANNIE		First FANNIE		Middle WILHELMINA		Last BERGER		2a. DATE KNOWN OF DEATH Month 11 Day 4 Year 1968		2b. HOUR 4:15 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 21, 1874		6. AGE (In years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year 19	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot				Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not an hospital give street address) MEMORIAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. (Smithson)			
14. FATHER'S NAME First Joseph Middle Worm Last _____				15. MOTHER'S MAIDEN NAME First _____ Middle _____ Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 220-52-8003		17. INFORMANT Mrs. Harry E. Hopkins, Preston, Md., RRD				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) See autopsy Report but most likely cause 4329 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) as of this standing is cerebral Anoxia due to (c) Complete Thrombosis of both Carotid arteries yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3327											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year Hour A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 11/6/68			
EXAMINER'S NAME (Type) Harold B. Plummer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) Caroline Preston							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Nov. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware					
24. FUNERAL DIRECTOR Trampten Funeral Home Frederick Md.				ADDRESS		25a. REC'D BY REGISTRAR NOV 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

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VR A15 (4)
30M REV. 1-54

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Constance G. Bloomfield</i>						2a. DATE OF DEATH Month Day Year <i>Nov 13 1968</i>			2b. HOUR MIN <i>5:15 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-30-1911</i>			6. AGE (In years lost birthday) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>TEACHING</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>PUBLIC SCHOOL</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>OXFORD</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>JACKS POINT</i>		
14. FATHER'S NAME First Middle Last <i>WALTER GRAVILLE</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>EMMA DAVIDSON</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>058-07-9185</i>		17. INFORMANT Address <i>HOWARD V.L. BLOOMFIELD OXFORD MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1750</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>10:50 AM</i> , 19 <i>68</i> , to <i>13:00</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>13:00</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Thurston Harrison MD</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>14 Nov 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>						22e. ADDRESS <i>Easton Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Nov 15, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OXFORD</i>		23d. LOCATION (City or Town) (County) (State) <i>OXFORD TALBOT MD</i>					
24. FUNERAL DIRECTOR <i>Charles Judge</i>						25a. REC'D BY REGISTRAR DATE <i>NOV 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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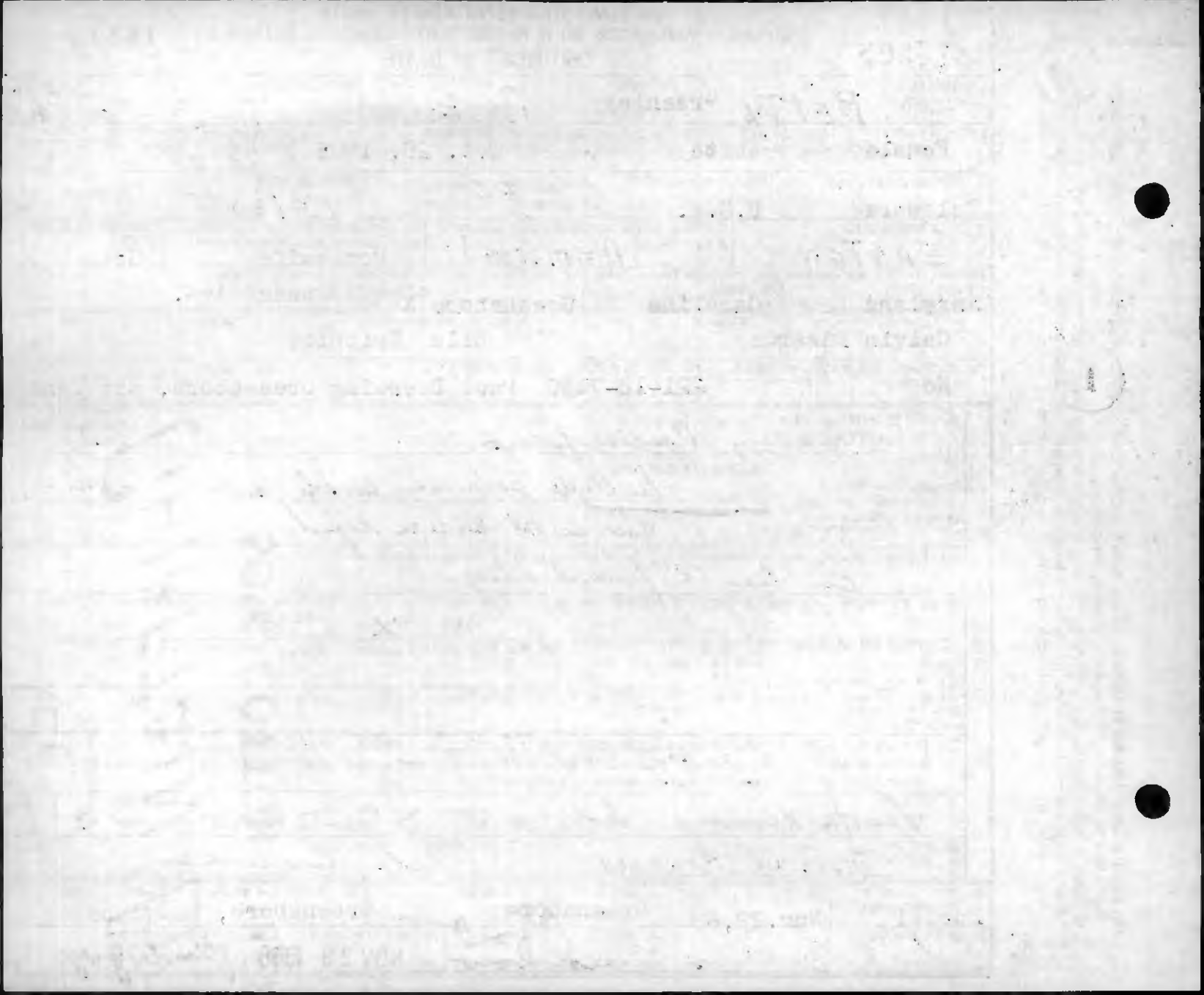
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16505									
16519									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>BETTY Greenley</i>			First Middle Last			2a. DATE OF DEATH Month Day Year <i>11-20-68</i>		2b. HOUR <i>3:30 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 28, 1925</i>		6. AGE (In years last birthday) <i>43</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.			
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Greensboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Sunset Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Calvin Edwards</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Ella Tribbitt</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>221-12-7150</i>		17. INFORMANT Address <i>Paul Breeding Greensboro, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>450 X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>multiple pulmonary emboli and</i> (c) <i>congenital cardiac defect.</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i> <i>2 wks.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>465X Em Hiler (R) femoral artery</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>17 Nov</i> , 19 <i>68</i> , to <i>20 Nov</i> , 19 <i>68</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>20 Nov</i> , 19 <i>68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (did) (<i>did not</i>) view the body after death.									
22b. SIGNATURE <i>Thorston Harrison M.D.</i> DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>25 Nov 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>						22e. ADDRESS <i>Carter, Long Road</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 22, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>		23d. LOCATION (City or Town) (County) (State) <i>Greensboro, Maryland</i>			
24. FUNERAL DIRECTOR <i>John E. Boulton Greensboro</i>				ADDRESS <i>2nd</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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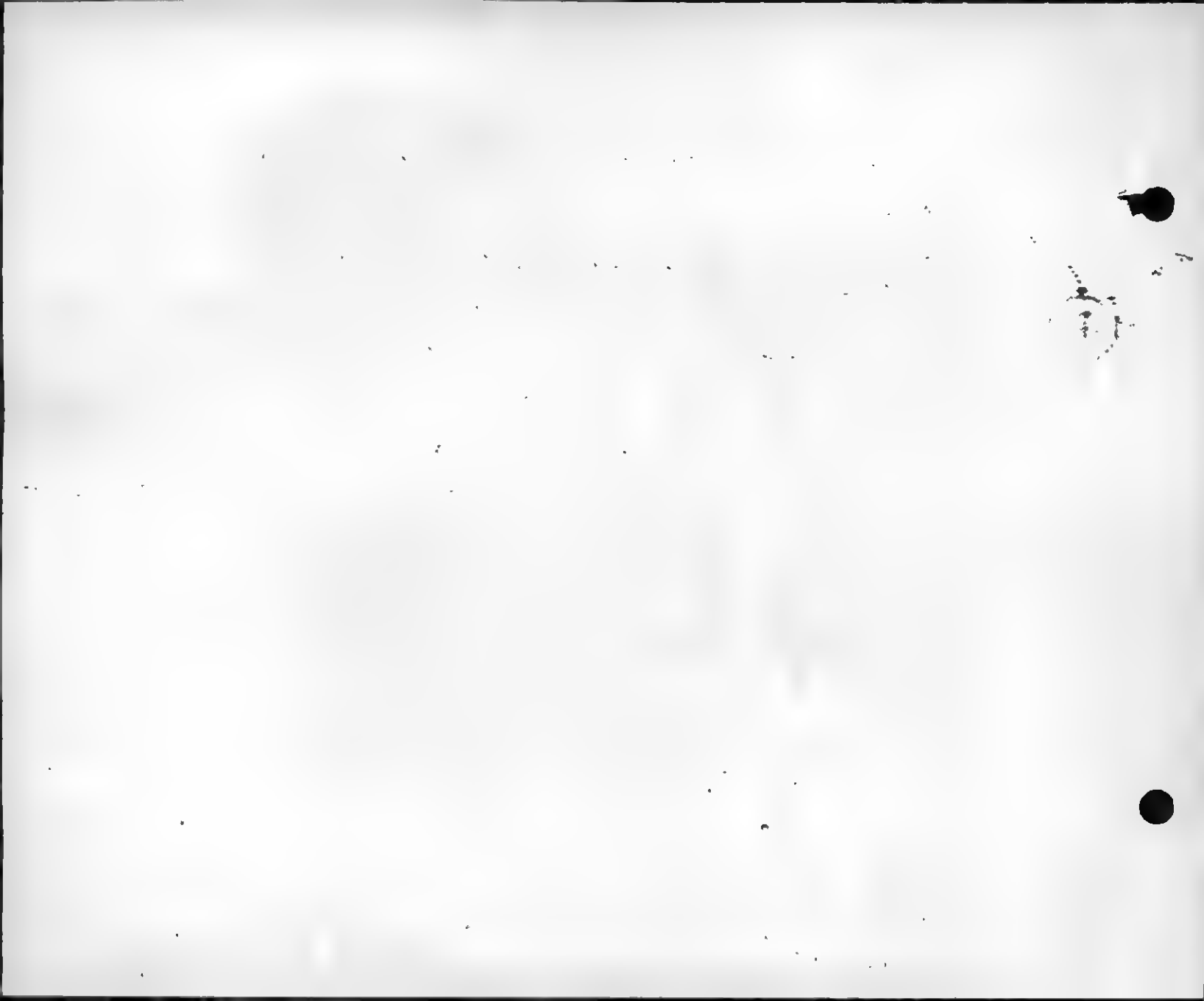
16506

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

105011

1. DECEASED NAME (Type or print) FRANKS E. BRICKELL			2a. DATE OF DEATH Month 11 Day 13 Year 68			2b. HOUR 9:09 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/14/1886		6. AGE (In years last birthday) 82 -YRS	
7a. BIRTHPLACE (State or foreign country) IND.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 115 S. HARRISON ST		14. FATHER'S NAME First William Middle McDonald Last McDonald		15. MOTHER'S MAIDEN NAME First ASTORIA Middle KELLER Last KELLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, he, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 216-54-9806		17. INFORMANT JAMES E. BRICKELL, EASTON, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Unknown							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-5-68
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 5-16 , 19 60 , to 11-13 , 19 68 , that (1)(we) last saw the deceased alive on 11-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1)(we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Trever, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11-13-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 11/15/1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or Town) (County) (State) WASHINGTON, DC	
24. FUNERAL DIRECTOR Maurice E. Newman		ADDRESS Easton, MD		25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

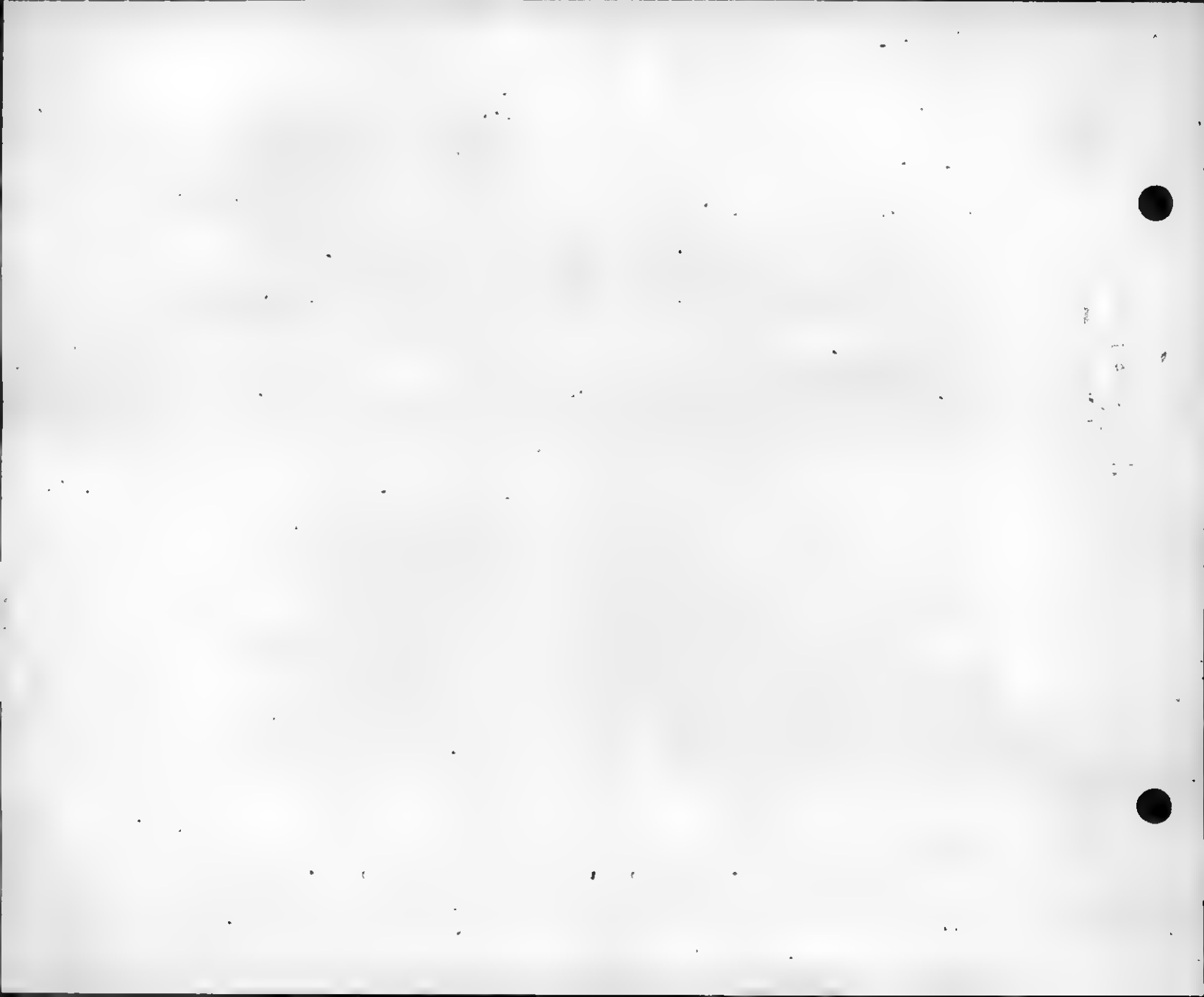


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		M dle		Last		2a. DATE OF DEATH		2b. HOUR	
Clarence						Brooks		Month Day Year 11 27 68		3:10 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		NEGRO		JUNE 21, 1925		43 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Talbot Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		MEMORIAL		LABORER		NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		TALBOT		EASTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		615 1/2 DOVER ST.			
14. FATHER'S NAME		First		M dle		Last		15. MOTHER'S MAIDEN NAME		First M dle Last	
Lylelesses						Brooks		Henrietta		Cooper	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
YES		22-may-45 to 1/10/46		219-14-3806		Lottie Brooks, 615 1/2 DOVER ST. EASTON Md. 21601					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral hemorrhage										< 4 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular										> 10 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1-11, 1968, to 11-27, 1968, that (I) (we) last saw the deceased alive on 11-27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Trever						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-27-68			
22d. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D.						22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		11-30-68		WILLIAMSBURG MARYLAND		NEAR EASTON TALBOT Md.					
24. FUNERAL DIRECTOR B.L. Vashell Easton Md.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE DEC 2 1968		J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
JAMES ELSWORTH BUCK						Month Day Year			11-13-68			
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		1/15/1891			77		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MD		USA				TALBOT Md.						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
EASTON			MEMORIAL			DISTRICT OF COLUMBIA			L.S. SURVIVOR			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD			TALBOT			EASTON		YES		115 E. DOVER ST.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
William H. Buck, Jr.				Sarah Jane Jones								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT			Address			
No				216-09-4571		Mrs. J. Elsworth Buck			EASTON, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										1 WK		
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC BRONCHITIS												
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRAIN SYNDROME												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 1968, to 11/13, 1968, that (I) (we) last saw the deceased alive on 11/12/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I), (we) (did) (did not) view the body after death.												
22b SIGNATURE						22c. DATE SIGNED						
Dorsett D. Smith						11/14/68						
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS			22f. REC'D BY REGISTRAR			22g. REGISTRAR'S SIGNATURE			
Dorsett D. Smith			M.D. Easton, Maryland			DATE NOV 19 1968			J. Charles Jones			
23a BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			11/16/1968		DRUID RIDGE			BALTIMORE, MD				
24. FUNERAL DIRECTOR ADDRESS												
Lawrence E. Luman & Son Easton, Md.												



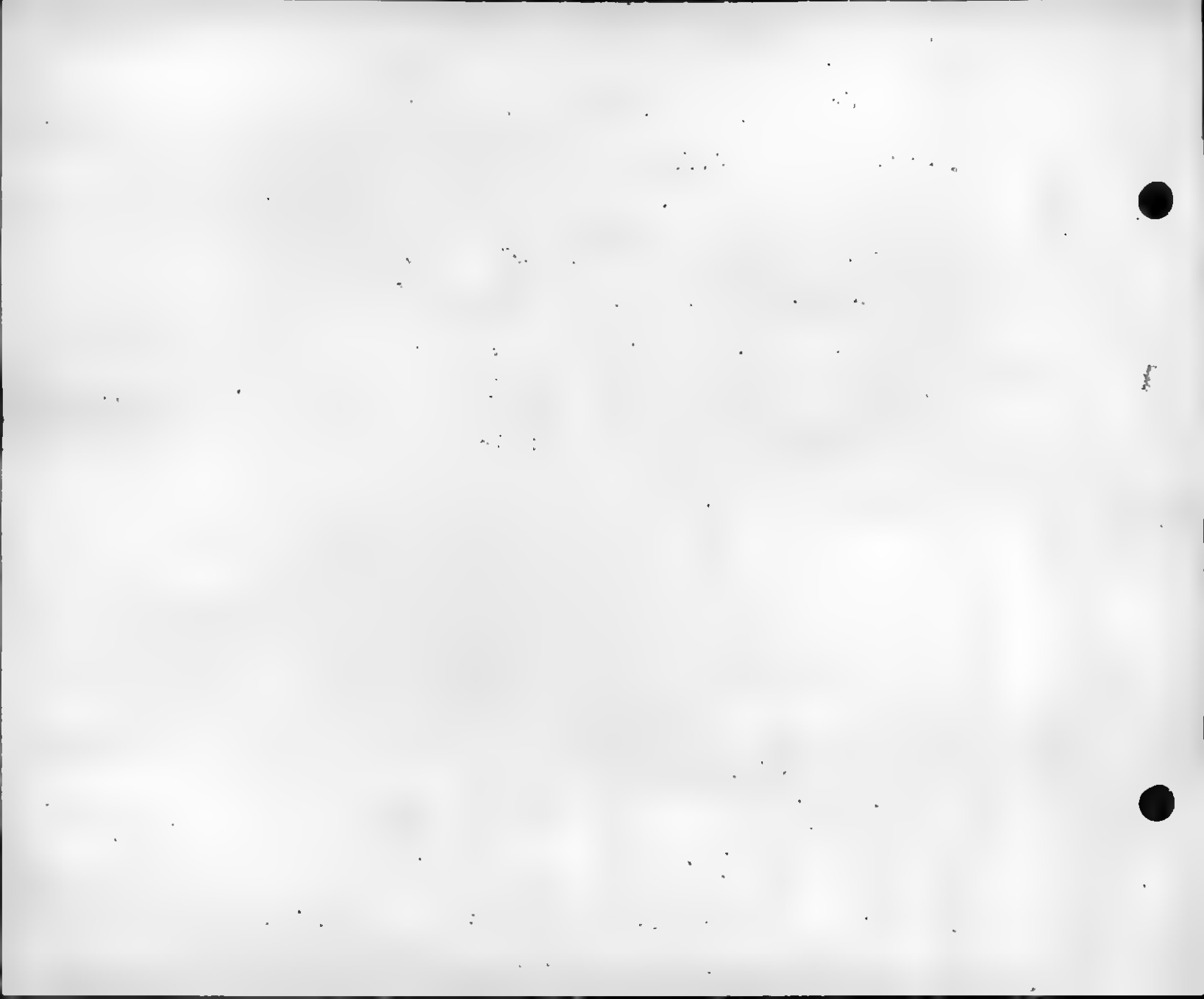
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16509												
16523												
1. DECEASED-NAME (Type or print) First Middle Last FRANCES ANN COCKEY						2a. DATE OF DEATH Month Day Year 11 11 68			2b. HOUR 10¹⁰ P M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH APRIL 27-1901			6. AGE (In years last birthday) 67 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md						
10 CITY OR TOWN OF DEATH EASTON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE PARENT			12b. KIND OF BUSINESS OR INDUSTRY SCHOOL			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY QUEEN ANNE STEVENSVILLE			13c INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER X X			
14 FATHER'S NAME First Middle Last RALPH L. HOYT			15 MOTHER'S MAIDEN NAME First Middle Last DONNA L. GORMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b SOCIAL SECURITY NO			17 INFORMANT Address J. SUDLER COCKEY STEVENSVILLE MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 403X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 744												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.												
22b. SIGNATURE E. C. H. Schmidt						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 Nov 68				
22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt						22e. ADDRESS Easton, Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 14		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE			23d. LOCATION (City or Town) (County) (State) STEVENSVILLE MD.					
24. FUNERAL DIRECTOR Colman L. Lane				ADDRESS Chesapeake Beach, Md		25a. REC'D BY REGISTRAR DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

MEDICAL CERTIFICATION



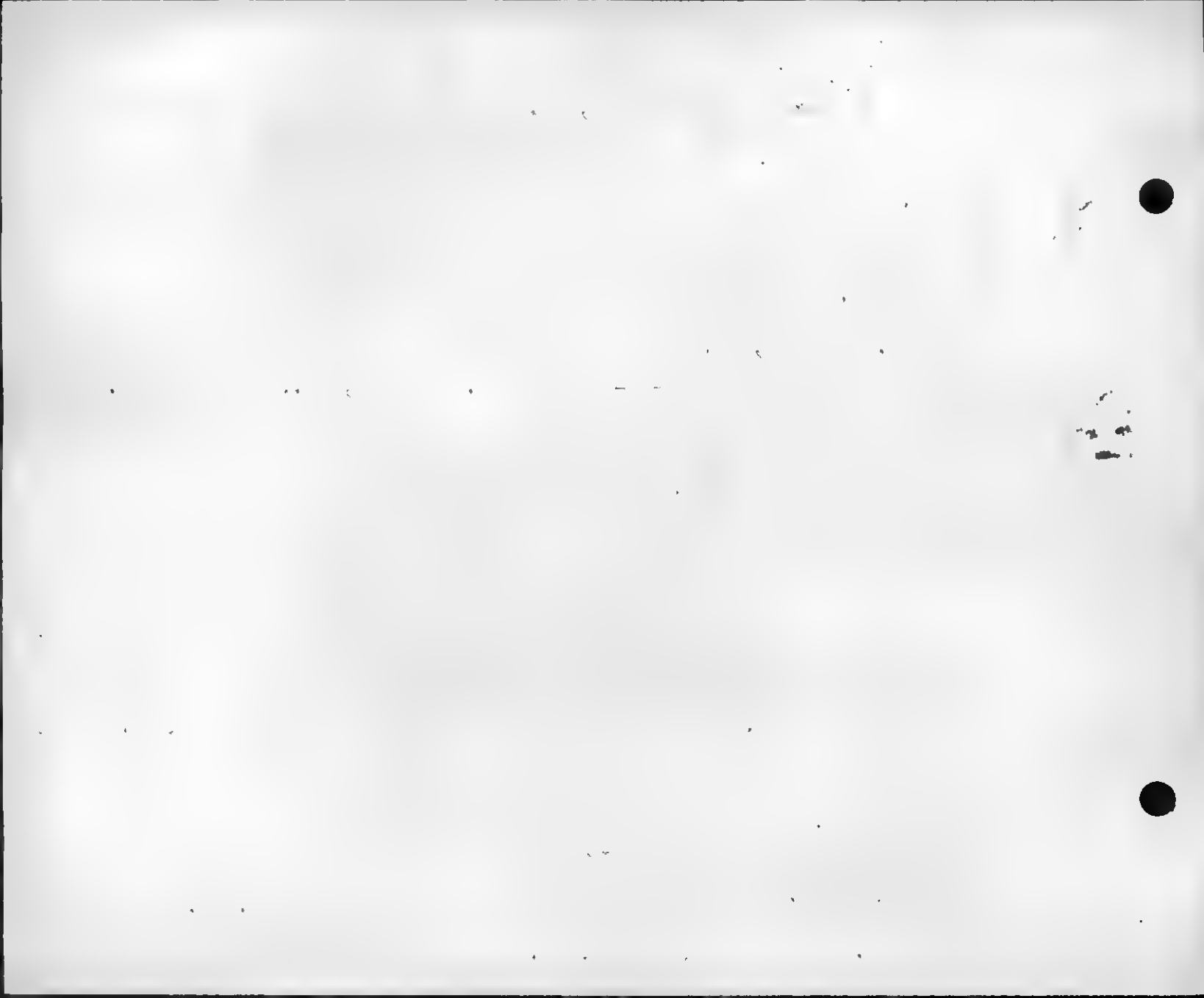
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2 & 9 Filed 12/3/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16510 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) Roy Raymond Milton Cummings, Jr.		First Middle Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-22-68c 10P M		2b HOUR	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 5/13/1930	6 AGE (in years last birthday) 38 YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month 11 Day 23 Year 1968		2d HOUR M
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Talbot	
10 CITY OR TOWN OF DEATH NR TILGHMAN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waterman		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Talbot		13c CITY OR TOWN Tilghman		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Roy M. Cummings, Sr.		15 MOTHER'S MAIDEN NAME Margaret Ridgeway		16a DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Korean		17 INFORMANT Roy M. Cummings, Sr., Tilghman, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EXPOSURE IN WATERS OF CHESAPEAKE BAY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) BOAT SANK BENEATH THEM DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH c9P		21b TIME OF INJURY Month, Day, Year 11-22-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) BOAT SANK			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) CHES. BAY		21f LOCATION Street or RFD No. OFF TILGHMAN		City or Town TALBOT County MD State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WELTY		EXAMINER'S NAME (Type) WELTY		22b DATE SIGNED 11-25		22c DEPUTY MEDICAL EXAMINER FOR	
23a BURIAL, CREMATION, REMOVAL, OR OTHER		23b DATE 11/25/1968		23c NAME OF CEMETERY OR CREMATORY Methodist		23d LOCATION (City or Town) (County) (State) Tilghman, Md.	
24 FUNERAL DIRECTOR AMURICE E. NEUNAM & SON, Easton, Md.				25a RECD BY REGISTRAR DATE NOV 26 1968		25b REGISTRAR'S SIGNATURE W. J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR A15
30M REV. 12-68

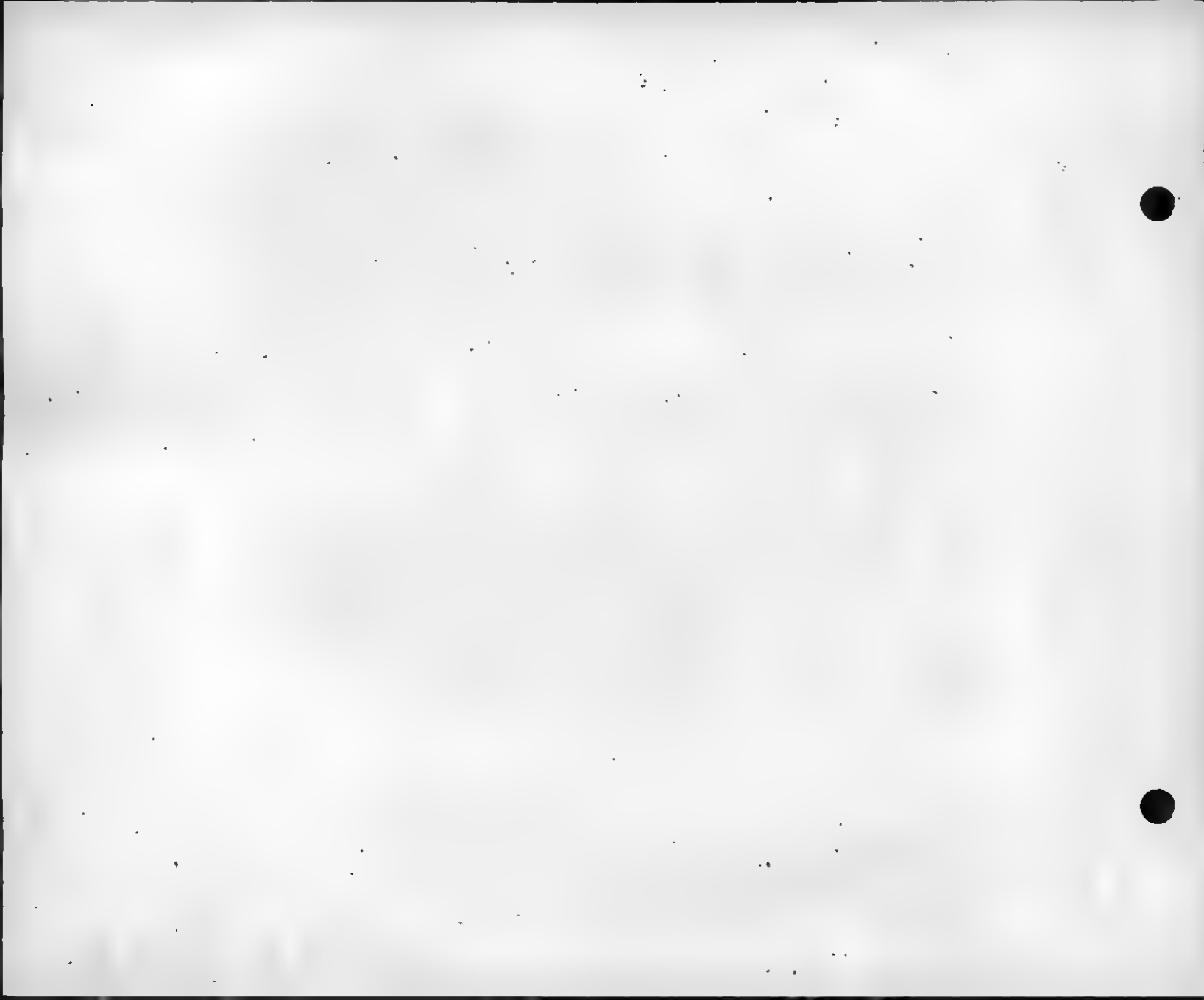
16511

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10500

1 DECEASED NAME (Type or print) Charles Norman Davis			2a. DATE OF DEATH Month 11 Day 1 Year 68			2b. HOUR 5:40 P.M.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 11/22/1892		6 AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN CARDOVA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14 FATHER'S NAME First Middle Last William H. Davis		15 MOTHER'S MAIDEN NAME First Middle Last GEORGIANA SAULSBURY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-34-2953		17 INFORMANT MRS. C. NORMAN DAVIS, CARDOVA, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right Middle Cerebral Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1966 , to 11/1 1968 , that (I) (we) last saw the deceased alive on 10/31 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. KRECH, JR.		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/2/68	
22d. PHYSICIAN'S NAME (Type) S. KRECH, JR.		22e. ADDRESS EASTON, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/4/1968		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City or Town) (County) (State) EASTON, MD	
24. FUNERAL DIRECTOR Maurice E Newman & Son		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

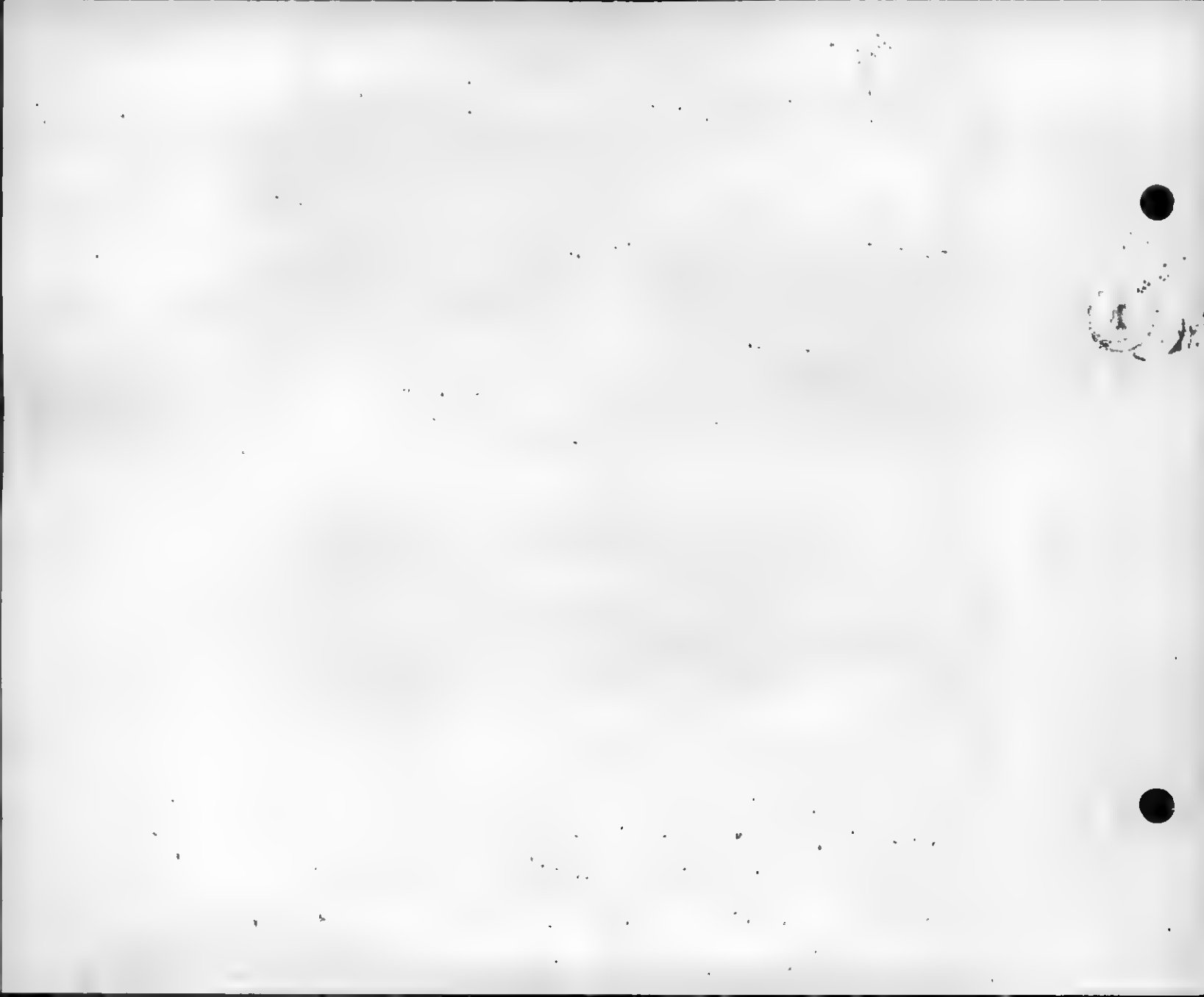
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First <u>GEORGE</u>		Middle <u>WOODROW</u>		Last <u>EVANS, JR.</u>		2a. DATE OF DEATH Month <u>11</u> - Day <u>5</u> Year <u>68</u>		2b. HOUR <u>6:45</u> M	
3 SEX <u>Male</u>		4 RACE <u>Negro</u>		5. DATE OF BIRTH <u>November 3, 1968</u>		6 AGE (In years last birthday) <u>—</u> YRS.		IF UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>21</u>		IF UNDER 24 HRS HOURS <u>21</u> MIN	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>TALBOT</u> Md					
10. CITY OR TOWN OF DEATH <u>EASTON</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>None</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Caroline</u>		13c. CITY OR TOWN <u>Federalburg</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Park Avenue</u>			
14. FATHER'S NAME First <u>George W.</u> Middle <u>Evans</u> Last <u>Evans</u>				15. MOTHER'S MAIDEN NAME First <u>Shirley</u> Middle <u>Ricketts</u> Last <u>Ricketts</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>George W. Evans, Federalburg, Maryland</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischaemic Heart Disease</u> <u>7100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>7100</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <u>19</u> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert M. (M.D.) Donaldson</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/4/68</u>	
22b. PHYSICIAN'S NAME (Type) <u>Robert M. (M.D.) Donaldson</u>		22e. ADDRESS <u>Easton, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 8, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Federalburg, Maryland</u>					
24. FUNERAL DIRECTOR <u>Frankton Funeral Home Federalburg, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 12 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16513 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) Anna Hemsley Flood			2a. DATE OF DEATH Month 11 Day 23 Year 68			2b. HOUR M			
3. SEX Female		4 RACE Negro		5. DATE OF BIRTH Oct. 11, 1884		6 AGE (In years lost birthday) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARR.ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Talbot Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY None			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Talbot		13c CITY OR TOWN Easton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 115 West St. Easton, Md.	
14. FATHER'S NAME First Middle Last William Hemsley			15. MOTHER'S MAIDEN NAME First Middle Last Racheal Grinnage						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219 42 9185		17 INFORMANT Mrs. Mamie Brooks Address 25 S. Hanson Street, Easton, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) intestinal Obstruction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obstipation and Senility									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 1-1 , 19 68 , to 11-23 , 19 68 , that (I) (we) last saw the deceased alive on 11-23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Richard Tyson DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 11-24-68	
22d. PHYSICIAN'S NAME (Type) Dr. Richard Tyson		22e ADDRESS 221 Glenwood Ave., Easton, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11/27/68		23c NAME OF CEMETERY OR CREMATORY Richards Memorial		23d. LOCATION (City or Town) (County) (State) Hammond St., Easton, Md.			
24. FUNERAL DIRECTOR J B Dashiell Funeral Home		ADDRESS 426 Dover St. Easton, Maryland		25a REC'D BY REGISTRAR DATE NOV 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

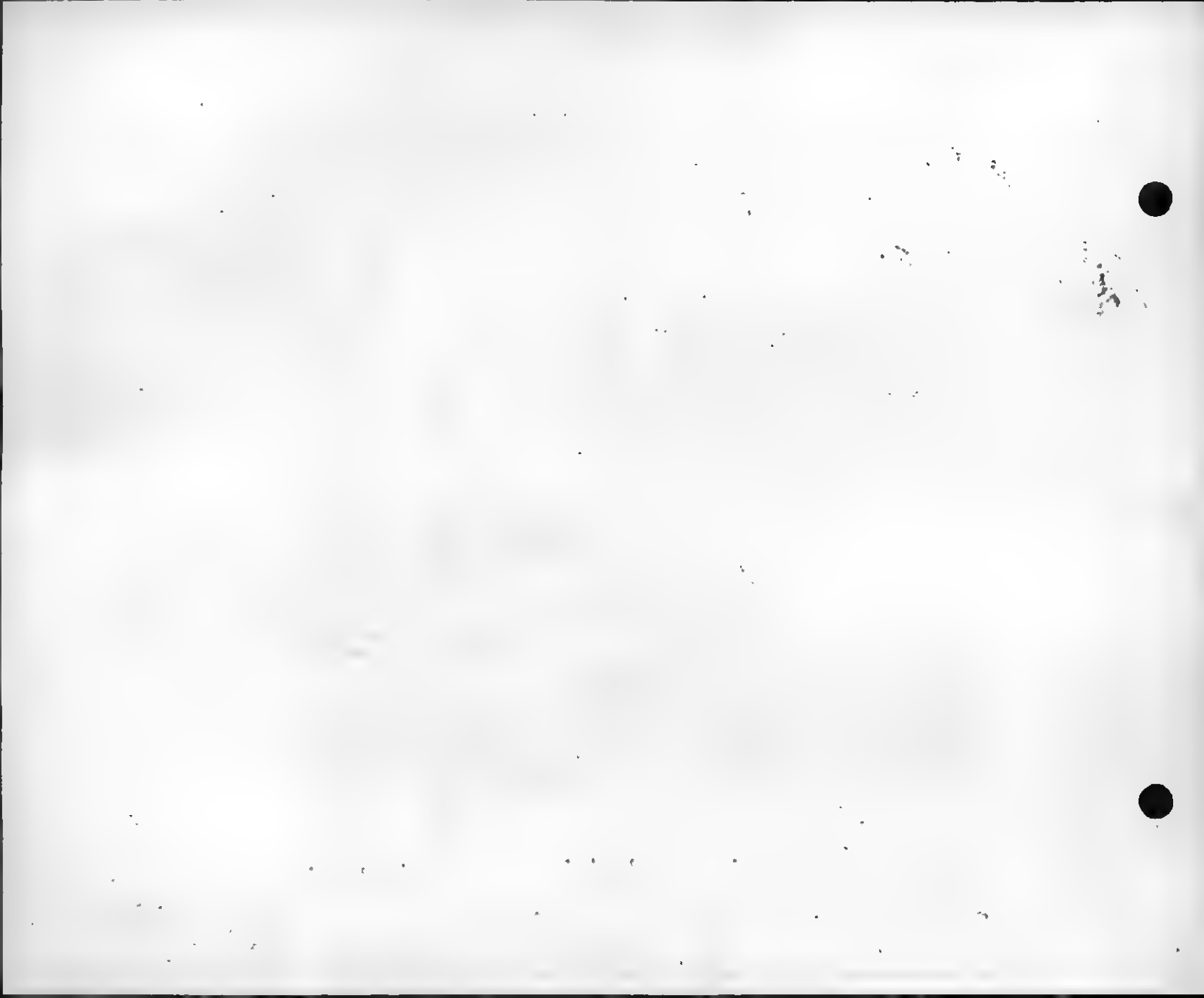


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VR A15
30M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 16514 Item 5 Film G 107 12/18/68 11W 16528 </div>											
1. DECEASED NAME (Type or print) Stella First Mountain Middle Mountain Last						2a. DATE OF DEATH Month Nov Day 27 Year 1968			2b. HOUR 10:15 M		
3. SEX Female		4. RACE white		5. DATE OF BIRTH 2/11/1884		6. AGE (In years last birthday) 82 YRS		7. UNDER 1 YEAR MONTHS 8 DAYS 10		7. UNDER 24 HRS HOURS 10 M.N.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD				13b. COUNTY CHARLOTTE		13c. CITY OR TOWN EDGELEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First WILLIAM Middle NOBLE Last				15. MOTHER'S MAIDEN NAME First ELIZABETH Middle O'DAY Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT ROLAND MOUNTAIN Address DENTON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Adrenal insufficiency											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 30 Oct , 19 68 , to 27 Nov , 19 68 , that (I) (we) last saw the deceased alive on 27 Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carney DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 11-30-68					
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.						22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL BURIED		23b. DATE NOV 30 1968		23c. NAME OF CEMETERY OR CREMATORY CONCORD		23d. LOCATION (City or Town) (County) (State) CONCORD ORR. MD.					
24. FUNERAL DIRECTOR CARROLL V. MOORE ADDRESS DENTON MD				25a. REC'D BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

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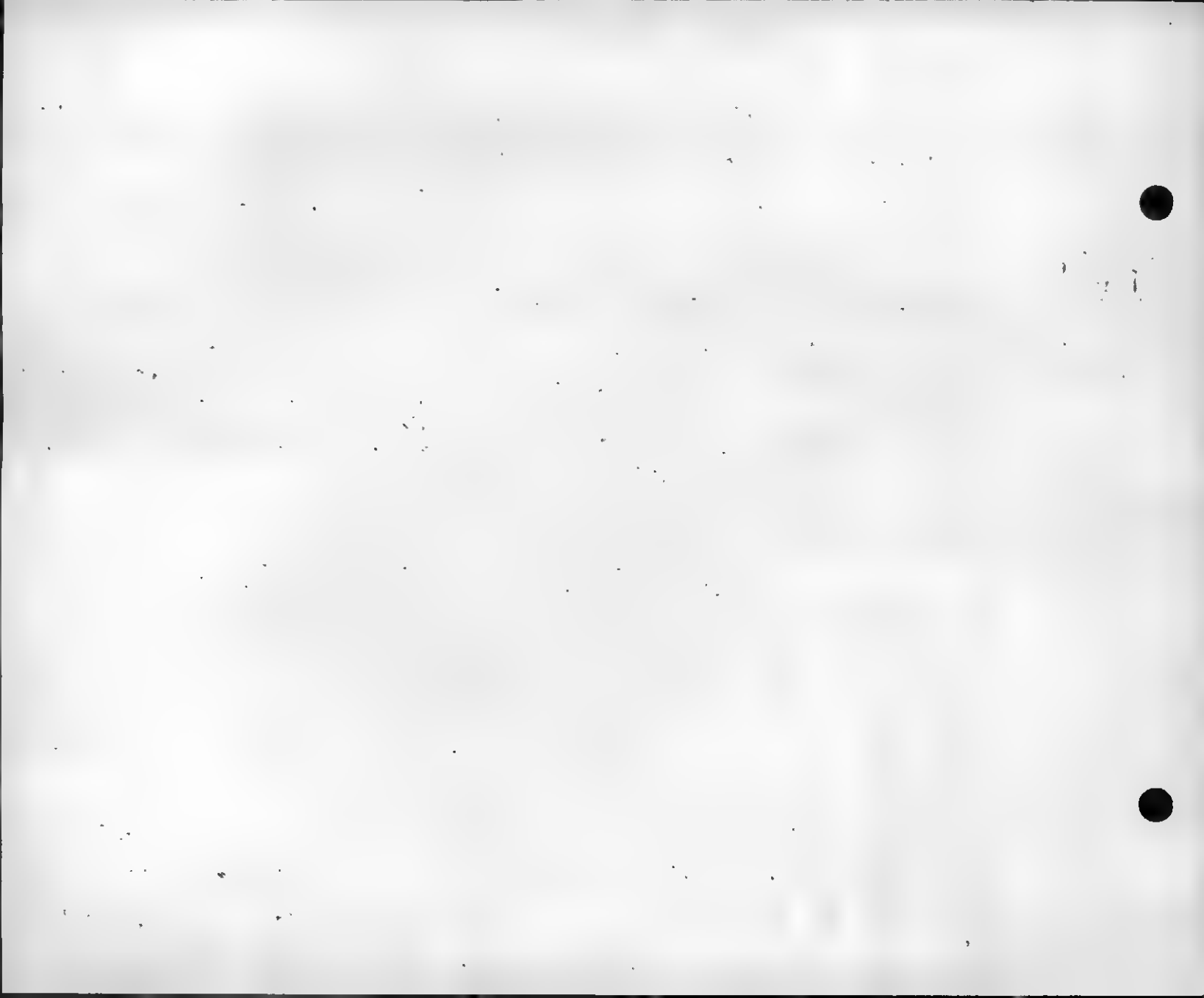
16515

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16529

1 DECEASED NAME (Type or print) <i>ELEANOR Elizabeth FRAMPTON</i>			First Middle Last			2a DATE OF DEATH Month <i>Nov</i> Day <i>25</i> Year <i>1968</i>			2b HOUR <i>5:00 PM</i>								
3 SEX <i>FEMALE</i>			4 RACE <i>WHITE</i>			5 DATE OF BIRTH <i>AUG 24, 1903</i>			6 AGE (in years lost birthday) <i>65</i> YRS.			7 IF UNDER 1 YEAR MONTHS DAYS			8 IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>TALBOXT</i> Md.								
10 CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>CLERK -</i>			12b KIND OF BUSINESS OR INDUSTRY <i>-</i>								
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>MARYLAND</i>			13b CITY OR TOWN <i>TALBOT ROYAL OAK</i>			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <i>-</i>								
14 FATHER'S NAME First Middle Last <i>CHARLES L. FRAMPTON</i>						15 MOTHER'S MAIDEN NAME First Middle Last <i>ANNIE B. LEONARD</i>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <i>218-16-5927</i>			17 INFORMANT <i>MRS MARIAN T. FERGUSON,</i>			Address <i>ROYAL OAK MD.</i>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>massive Rt Cerebro Vascular</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>332X</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>atherosclerotic cardio vasc. Diabetes M</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>1956</i> , to <i>11-25</i> , 1968; that (I) (we) last saw the deceased alive on <i>11-24</i> , 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b SIGNATURE <i>Wm M Reese MD</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>11-26-68</i>								
22d PHYSICIAN'S NAME (Type) <i>Wm M Reese</i>						22e ADDRESS <i>St Michael's Med</i>											
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>Nov 27, 1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Easton, Maryland</i>								
24 FUNERAL DIRECTOR <i>Amos E Leonard, St. Michael's, Md</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 2 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

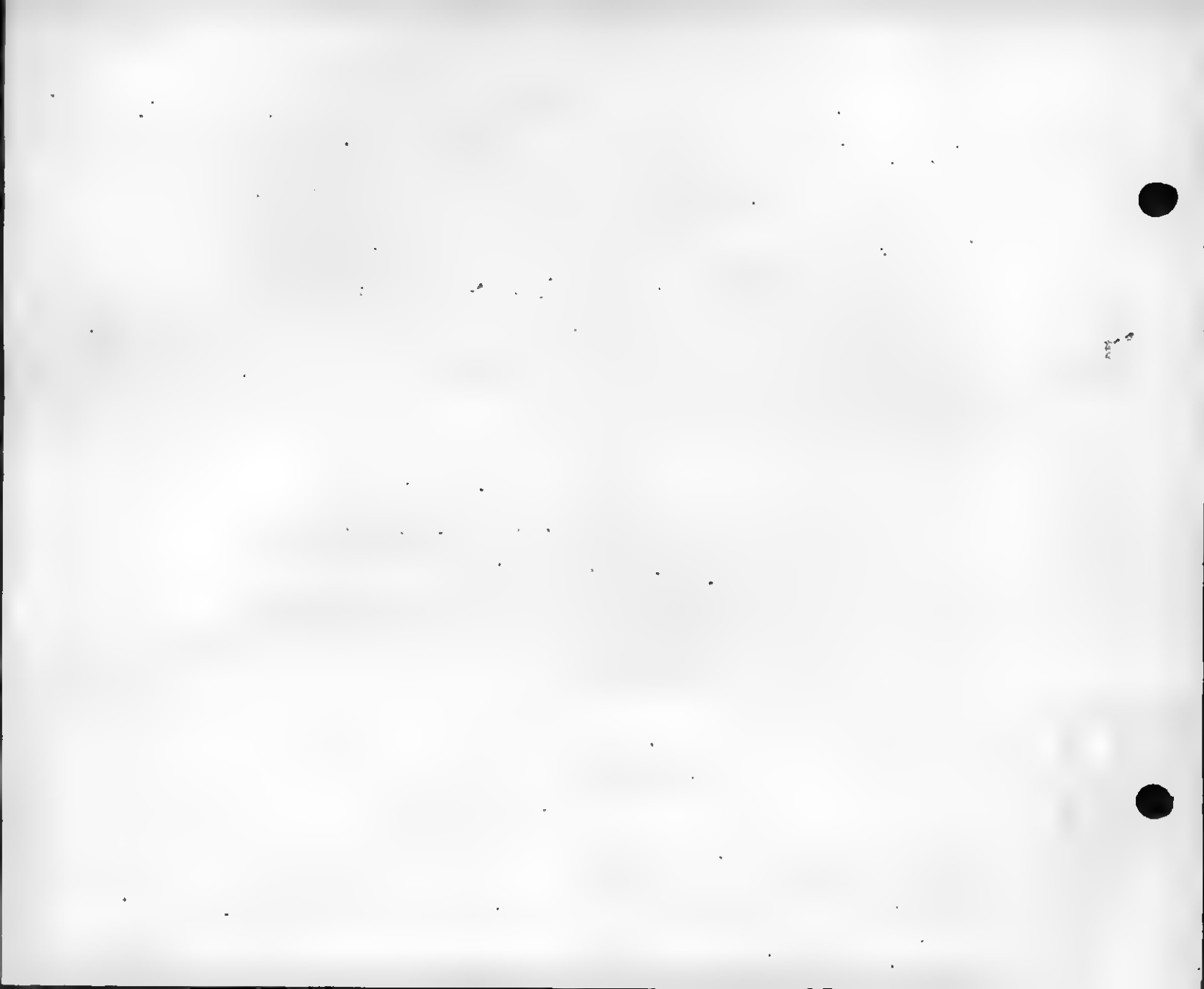
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16515 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CARRIE GEISEL						2a. DATE OF DEATH Month 11 Day 26 Year 68			2b. HOUR 7:45 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12-11-96			6. AGE (in years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS 11 DAYS 26		IF UNDER 24 HRS HOURS 7 MIN 45
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md					
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD COUNTY CHARLOTTE				13c. CITY OR TOWN DENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First GEORGE Middle HENNING Last MARTHA				15. MOTHER'S MAIDEN NAME First MARTHA Middle HUFFMAN Last HUFFMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address PAUL GEISEL DENTON MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myeloid metaplasia DUE TO, OR AS A CONSEQUENCE OF (c) Uterine myeloid metaplasia											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 11 Day 26 Year 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. Capitol City or Town Princeton County MD State MD							
22a. I certify that (I) (this hospital) attended the deceased from 11/26/68 , 19 68 , to 11/26/68 , 19 68 , that (I) (we) last saw the deceased alive on 11/26/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. C. H. Schmidt		22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Capitol, Maryland		22e. DATE SIGNED 27 Nov 68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Nov. 29, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON MD					
24. FUNERAL DIRECTOR CHARLES V. MESSER		ADDRESS Capitol, Maryland		25a. REC'D BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE W. C. M. Judge					

16515



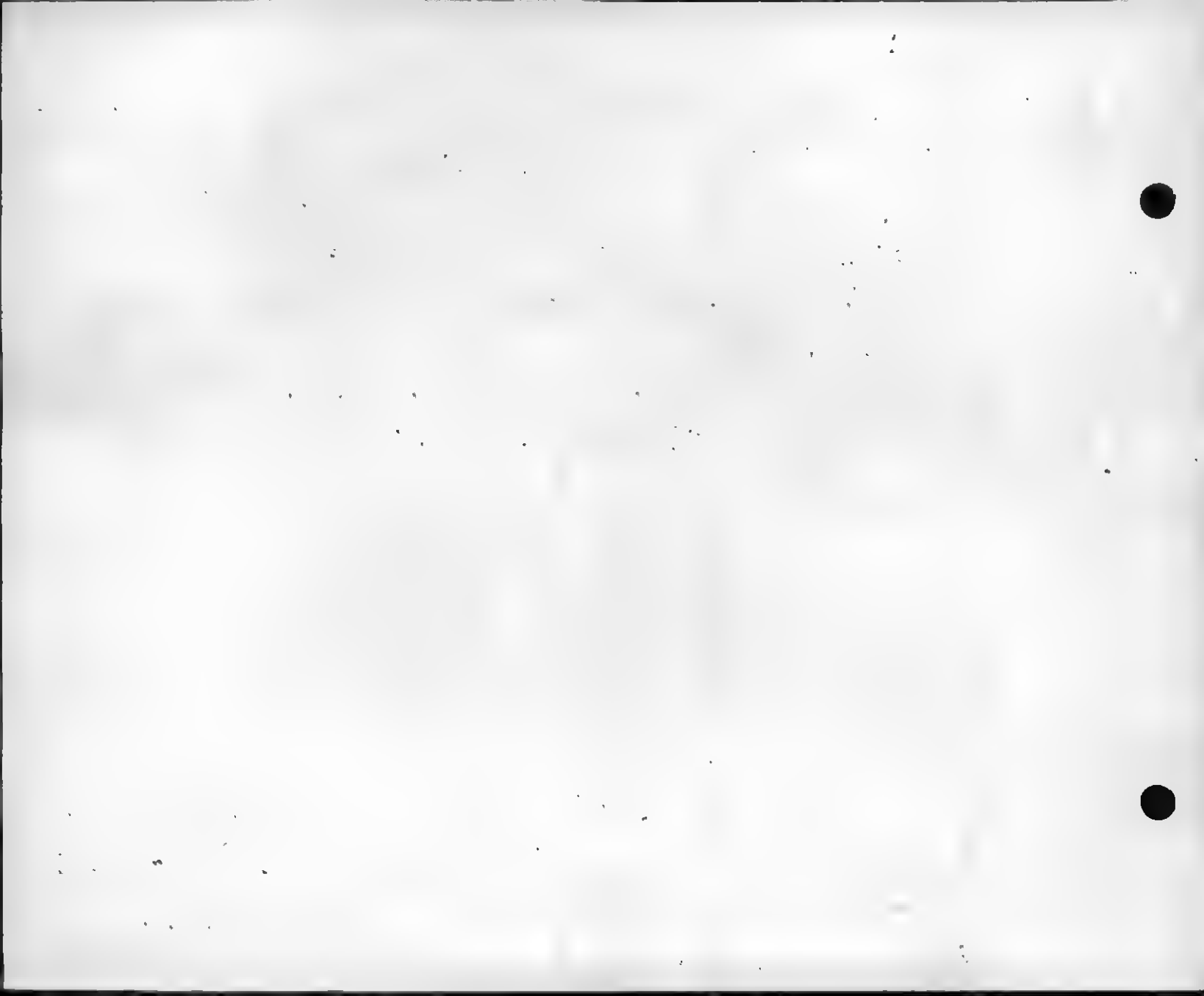
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) MARY First King Middle Goss Last		2a DATE OF DEATH Month 11 Day 17 Year 68		2b HOUR 11 ⁴⁷ ^A M
3 SEX Female	4 RACE White	5 DATE OF BIRTH 6/29/1906	6 AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) W.V.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Talbot Md.	
10 CITY OR TOWN OF DEATH E. Aston	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housework	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Talbot	13c CITY OR TOWN Trappe	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER RFD
14 FATHER'S NAME First William T. Gaskell Middle Last		15 MOTHER'S MAIDEN NAME First Cuba Niblo Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b SOCIAL SECURITY NO. Unkn.		17 INFORMANT Charles G. King, 4th Delaware, Ohio Address RFD #1
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 11-19 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Charles G. King		DEGREE	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c DATE SIGNED 11/18/68
22d PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22e ADDRESS Trappe, Md.		
23a BURIAL CREMATION cremation	23b DATE 11/18/1968	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d LOCATION (City or Town) (County) (State) Washington, D.C.	
24 FUNERAL DIRECTOR Maunice E. Murren + Son Eastern		ADDRESS	25a REC'D BY REGISTRAR NOV 19 1968	25b REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form and Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16518

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) EUGENE Roland GROCE			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 11-10-1968			2b HOUR M <input type="checkbox"/> AM <input checked="" type="checkbox"/>			
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 3-29-1949	6 AGE (in years last birthday) 19 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> M <input type="checkbox"/>			
7a BIRTHPLACE (State or foreign) Denton, Md.,		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT			
10 CITY OR TOWN OF DEATH Gordova, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp, Easton, Md			12a USUAL OCCUPATION (Kind of work done during most of workable life, even if retired) laborer		12b KIND OF BUSINESS OR INDUSTRY None		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) Maryland			13b CITY OR TOWN Fredericksburg	13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER RI# 2, Box# 243				
14 FATHER'S NAME First Roland Middle C. Groce Last 			15 MOTHER'S MAIDEN NAME First Hazel Middle Baynard Last (deceased)						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown)			16b SOCIAL SECURITY NO 220-48-3506		17 INFORMANT Father (address given above)			ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Head injury DUE TO, OR AS A CONSEQUENCE OF Auto accident (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8:00 PM									
19a DATE OF OPERATION 8:00 PM			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Passin			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A M 11-10-1968 11 PM		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Car struck concrete culvert					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) hi-way		21f LOCATION Street or R.F.D. No Gordova		City or Town Talbot		County 114d	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Louis Welty			EXAMINER'S NAME (Type) WELTY			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 11-10-68	
23a BURIAL, CREMATION, or other disposition (Specify) Burial			23b DATE 11-13-1968		23c NAME OF CEMETERY OR CREMATORY St. Paul Church Cem		23d LOCATION (City or Town) (County) (State) Williston, Caroline, Md		
24 FUNERAL DIRECTOR Charles J. Denton, Md.			ADDRESS			25a REC'D BY REGISTRAR NOV 18 1968		25b REGISTRAR'S SIGNATURE Charles J. Denton	



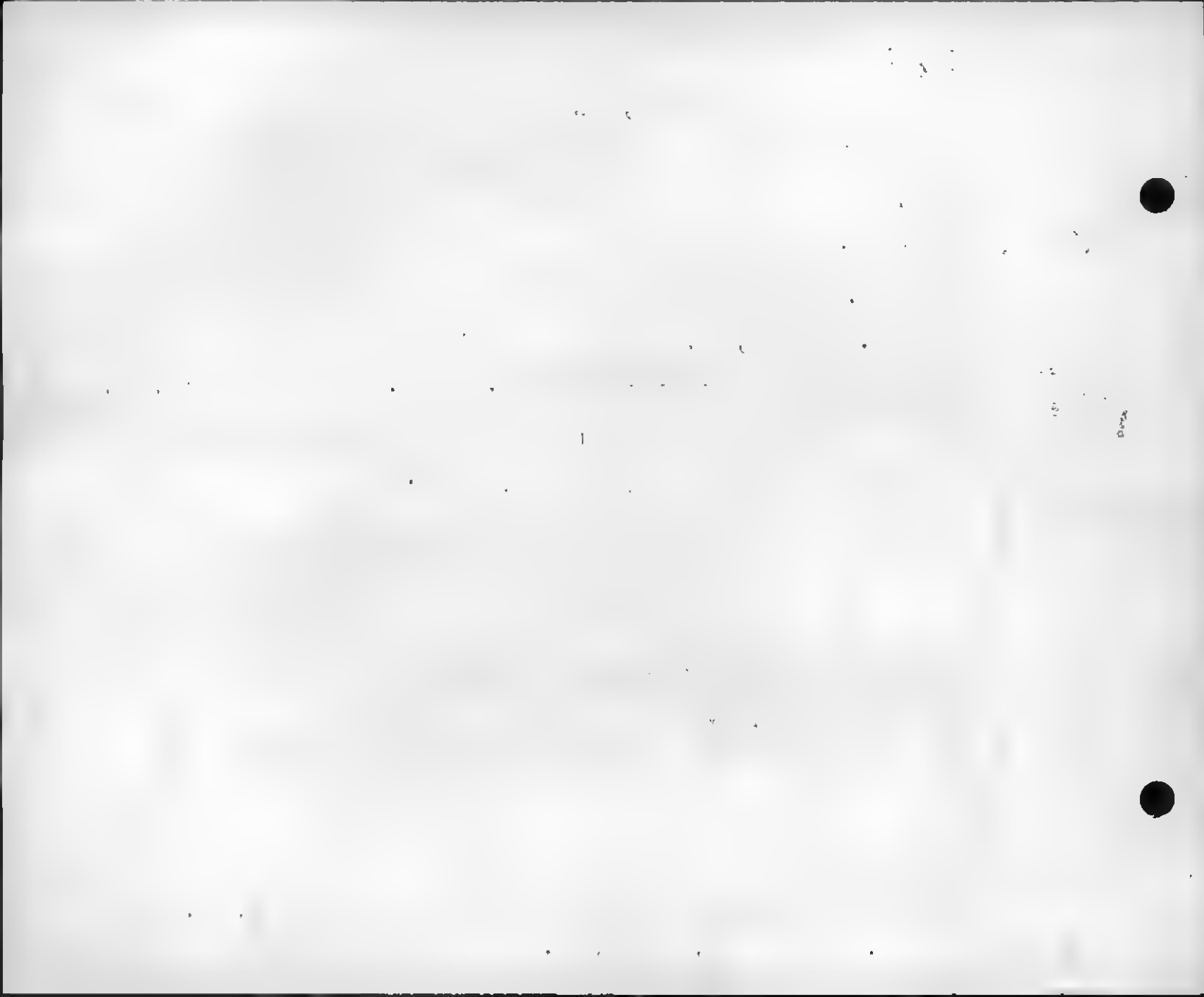
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2 & 9 Filed 11/27/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12/3/68 kk 16519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <i>Orem Nelson Haddaway, Sr.</i>			First Middle Last			2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> MONTH <i>2</i> DAY <i>22</i> YEAR <i>68</i>			2b. HOUR <i>10 P M</i>				
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>9/2/1935</i>		6 AGE (In years last birthday) <i>33</i> YRS		7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>			
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Talbot</i>				
10. CITY OR TOWN OF DEATH <i>NR TILGHMAN</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired) <i>Waterman</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Wittman</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME <i>Roland D. Haddaway, Sr.</i>						15. MOTHER'S MAIDEN NAME <i>Mamie Crockett</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Korean</i>						16b. SOCIAL SECURITY NO. <i>219-34-2822</i>		17. INFORMANT ADDRESS <i>Mrs. Orem N. Haddaway, Wittman, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>EXPOSURE IN WATERS OF CHESAPEAKE BAY</i> <i>0307</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>BOAT SANK BENEATH THEM</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year <i>69P M 11-22-68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>BOAT SANK</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>CHES. BAY</i>		21f. LOCATION Street or R.F.D. No <i>OFF TILGHMAN</i>		City or Town <i>TALBOT</i>		State <i>MD</i>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Louis Welty</i>						M.D. <i>WELTY</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>11-25-68</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>WELTY</i>						FOR DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>11/25/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>			23d. LOCATION (City or Town) (County) (State) <i>Tilghman, Md.</i>					
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM & SON, Easton, Md.</i>							25a. REC'D BY REGISTRAR <i>NOV 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>JOHN J. JUDGE</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

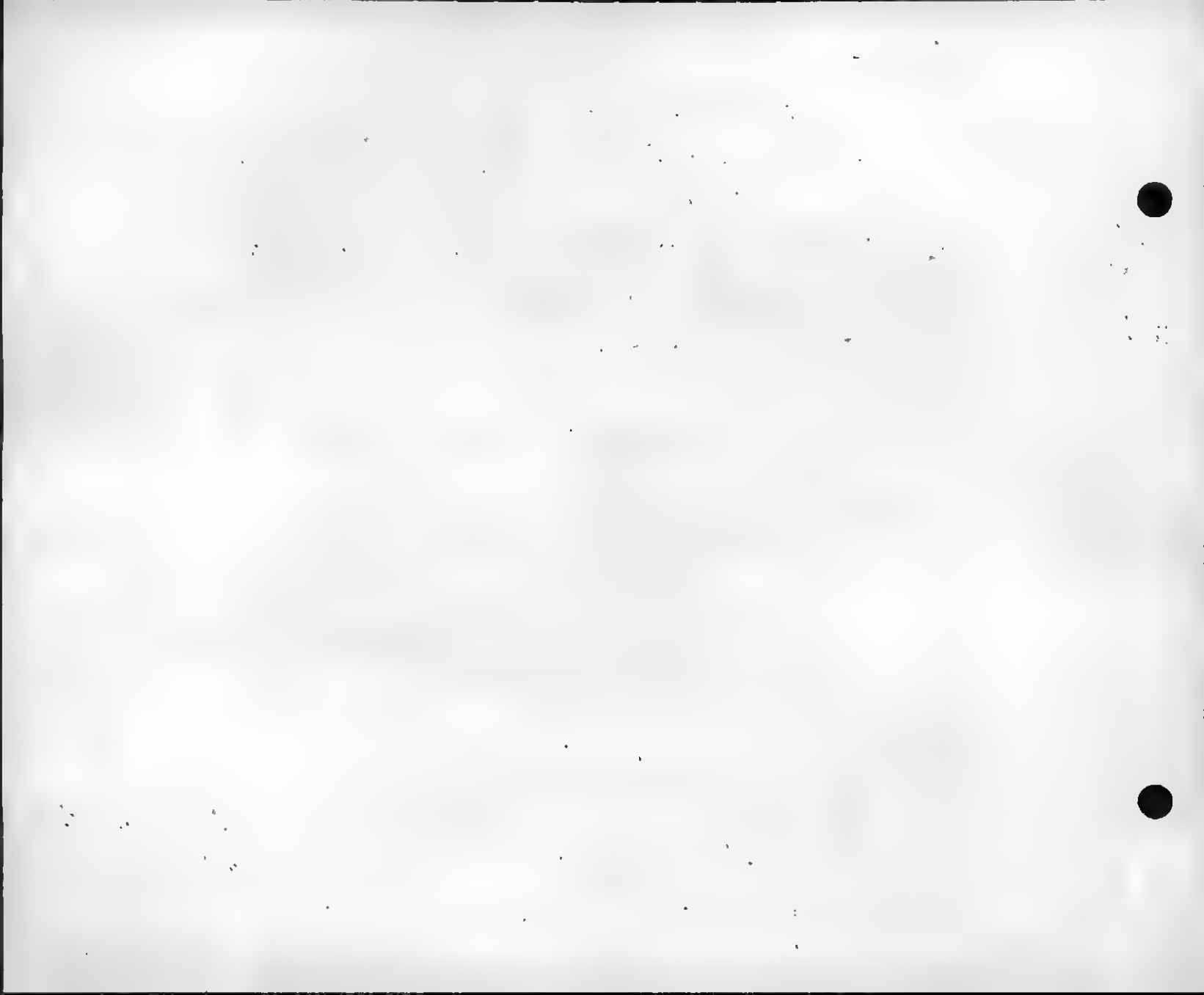
16520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1053

1 DECEASED NAME (Type or print) First Middle Last Wallace Bruce Hopkins			2a DATE OF DEATH Month Day Year 11 22 68			2b HOUR 9 A M					
3 SEX M		4 RACE WHITE		5. DATE OF BIRTH OCT 1, 1880		6. AGE (In years last birthday) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md					
10. CITY OR TOWN OF DEATH PASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) HUMBER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. CITY OR TOWN DENTON			13c. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last WILLIAM HOPKINS			15 MOTHER'S MAIDEN NAME First Middle Last ADDA DILL			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Wallace Hopkins			Address Denton 4								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. C. H. Schmidt			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 23 Nov 68		
22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt			22e. ADDRESS Canton, Md			22f. ADDRESS 21601					
23a. BURIAL, CREMATION, BURNING, ETC.			23b. DATE NOV. 26, 1968			23c. NAME OF CEMETERY OR CREMATORY DENTON			23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD.		
24. FUNERAL DIRECTOR CHARLES V. MOORE			ADDRESS DENTON			25a. REC'D BY REGISTRAR DATE NOV 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

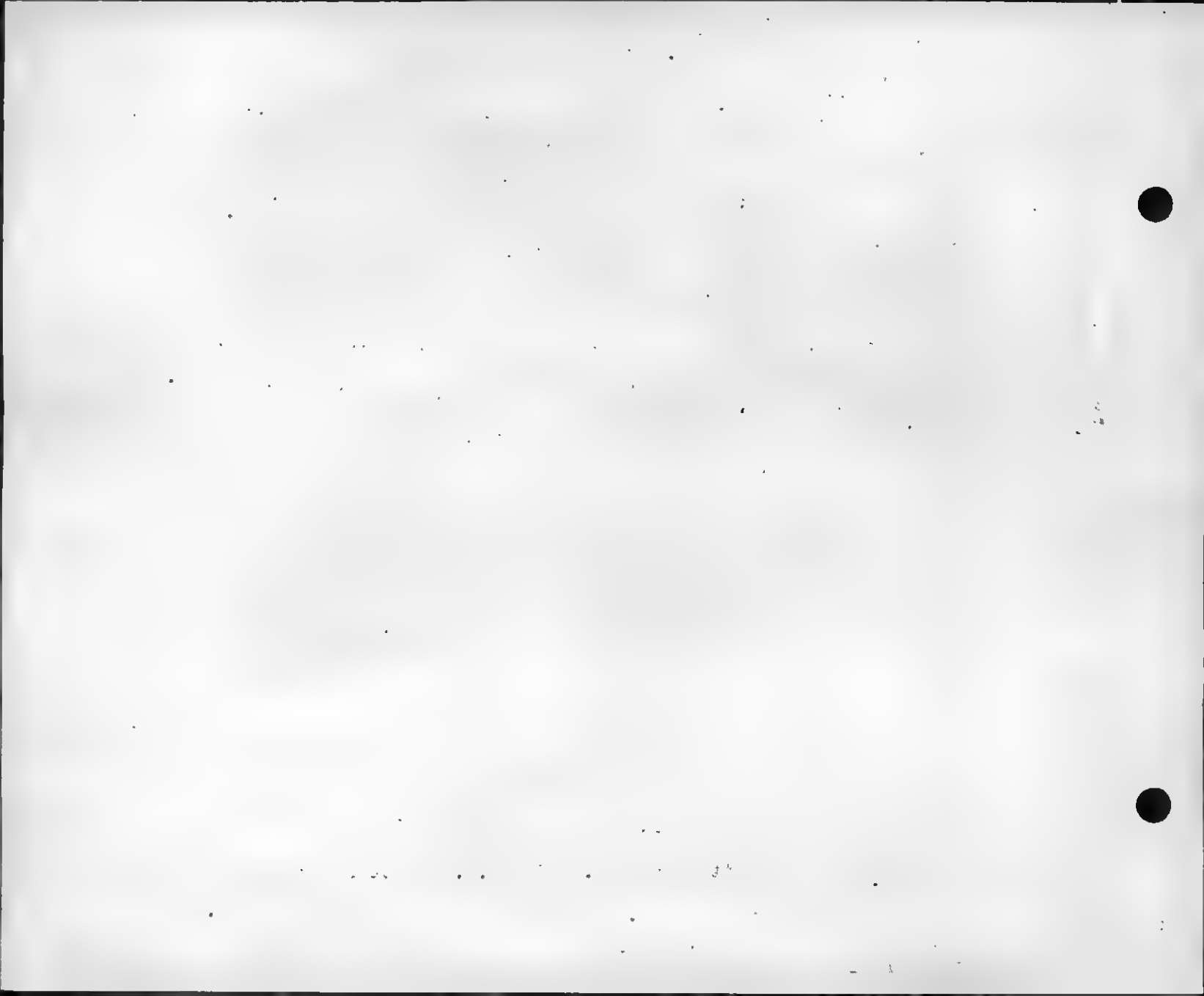
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV 1/68

19 16521

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last EDWARD A. HURD			2a. DATE OF DEATH Month Day Year 11-11-68		2b. HOUR 1:30 PM
3. SEX Male		4. RACE white		5. DATE OF BIRTH 5/23/1895	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) YRS MONTHS DAYS 73	
7c. BIRTHPLACE (State or foreign country) Mass.		7d. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		9. COUNTY OF DEATH TALBOT	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
14. FATHER'S NAME First Middle Last C. Russell Hurd		15. MOTHER'S MAIDEN NAME First Middle Last Mary Newell Hurd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes WW 1 & WW II		16b. SOCIAL SECURITY NO. 058 10 5673 A		17. INFORMANT Address Mary O. Hurd Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1971 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 119					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 68 , to 11-10 , 19 68 , that (I) (we) last saw the deceased alive on 11-9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dorsett D. Smith M.D.				22c. DATE SIGNED 11/12/68	
22d. PHYSICIAN'S NAME (Type) Dorsett D. Smith M.D.				22e. ADDRESS Easton, Maryland 11/12/68	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem. near Chestertown, Md.	
24. FUNERAL DIRECTOR W. Wells		ADDRESS CHESTERTOWN, MD		25a. REC'D BY REGISTRAR NOV 15 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

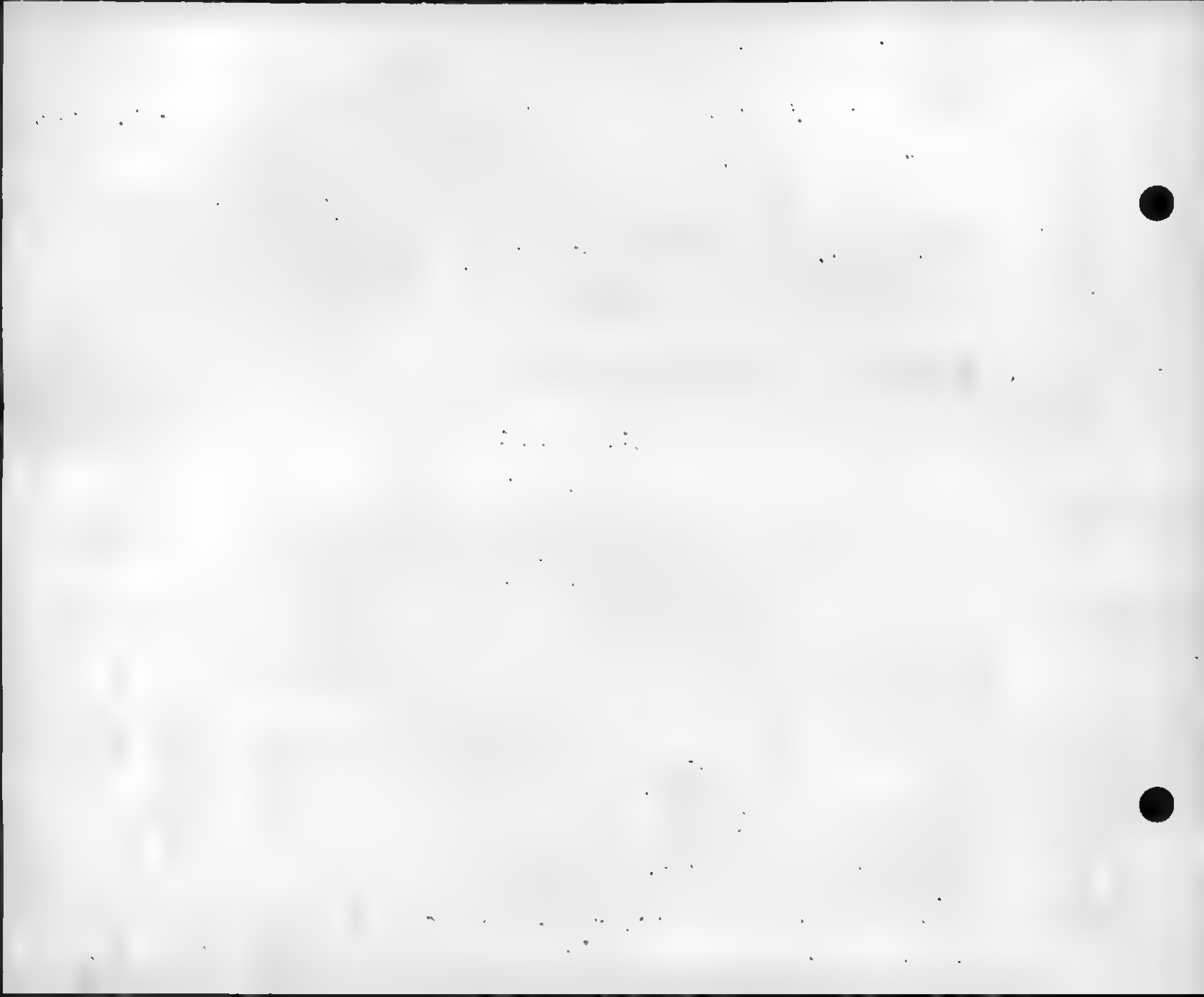


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 7, 8 & 13 ^{File 106}
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
11/13/68 kk 16522
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CHARLES D JAMES			2a. DATE OF DEATH Month 11 Day 3 Year 1968			2b. HOUR 12:15 AM	
3 SEX M		4 RACE N		5 DATE OF BIRTH		6 AGE (In years lost birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIM. TSP YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or, unknown		16b. SOCIAL SECURITY NO	
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wks (?)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Severe malnutrition							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 24 , 19 68 , to Nov. 3 , 19 68 , that (I) (we) last saw the deceased alive on Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thorston Harrison MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov 68	
22d. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22e. ADDRESS Easton, Maryland		23a. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23b. LOCATION (City or Town) (County) (State) Baltimore, Md.	
23c. DATE 11-5-68		23d. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23e. LOCATION (City or Town) (County) (State) Baltimore, Md.		23f. DATE NOV 8 1968	
24. FUNERAL DIRECTOR Harrison Funeral Home		24a. ADDRESS 11-5-68		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304K REV 1/68

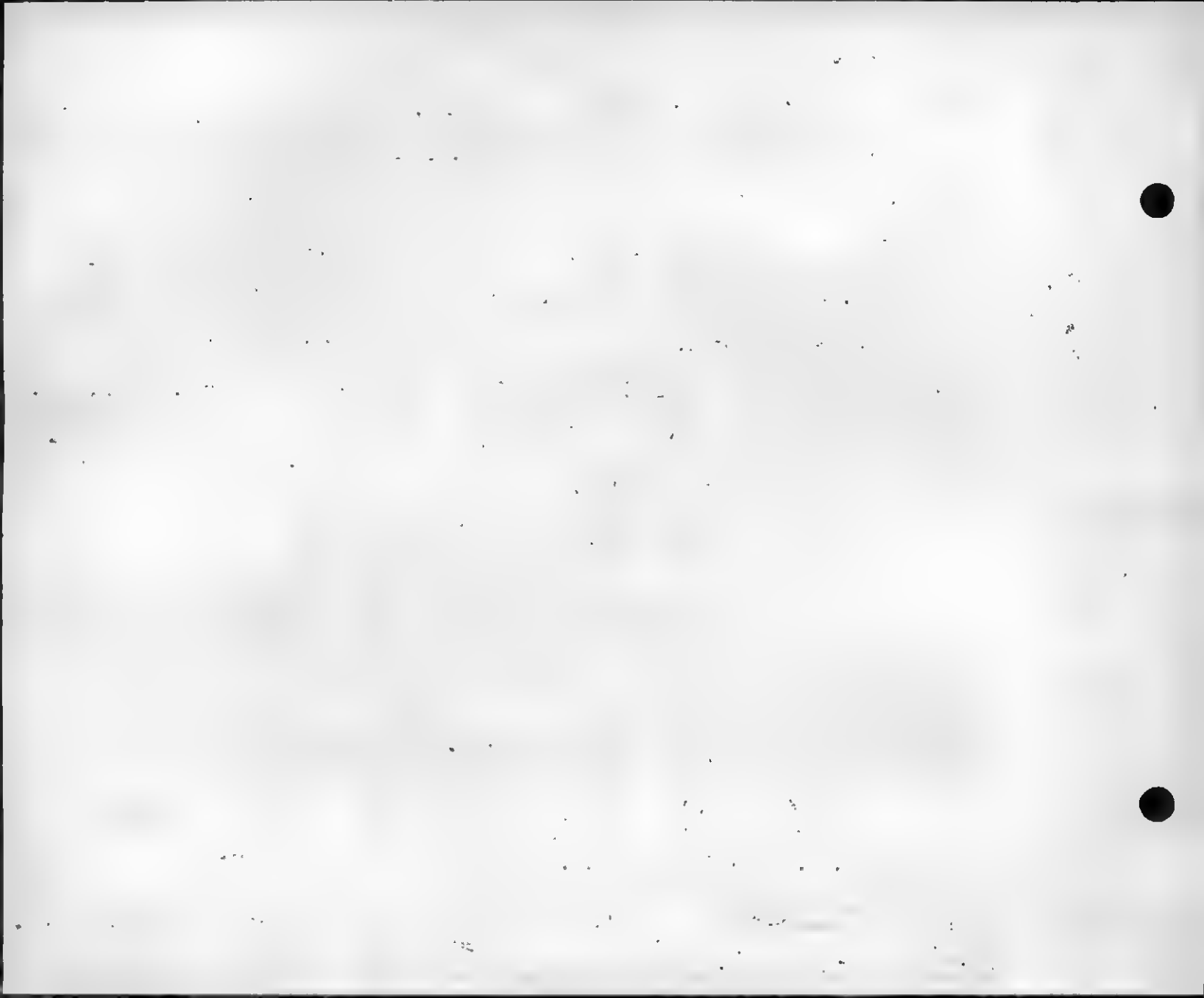
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
COURTNEY					JENKINS				Month 11 Day 2 Year 68		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
MALE		WHITE					68 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD			U.S.A.					TALBOT MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON			MEMORIAL								
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			CAROLINE			USA					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
JOHN					JENKINS				MARY E. COLEMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
YES			10011			Mrs. May JENKINS			DENTON MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>hemia</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>urethral obstruction</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma prostate</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
177X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year 19								
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from 9-30-1968 to 11-2-1968, that (I) (we) lost the deceased alive on 11-2-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
[Signature]			11/4/68			Fitzgerald		M.D.		11/4/68	
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)	
Burial			NOV. 6, 1968		DENTON			DENTON		CAR. MD.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles Moore Denton						DATE NOV 12 1968		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>William Clifton Johnson</i>						2a. DATE OF DEATH		2b. HOUR	
						Month <i>Nov.</i> Day <i>15</i> Year <i>1968</i>		<i>8 a m</i>	
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5 DATE OF BIRTH <i>Jan. 13, 1910</i>		6 AGE (In years last birthday) <i>58</i> YRS		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>		12b KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Laborer</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Caroline</i>		13c CITY OR TOWN <i>Henderson</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>None</i>	
14. FATHER'S NAME First Middle Last <i>William Johnson</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Daisy Thomas</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>222-01-3040</i>		17 INFORMANT <i>Gertrude Johnson</i>		Address <i>Henderson, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture</i>									
DUE TO, OR AS A CONSEQUENCE OF <i>Metastatic carcinoma of the breast</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>undetermined</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>undetermined</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)									
21f. LOCATION Street or RFD No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <i>10-11-1968</i> , to <i>11-15-1968</i> , that (I) (we) last saw the deceased alive on <i>11/14</i> <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. T. B. Ambler M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <i>11/16/68</i>									
22d. PHYSICIAN'S NAME (Type) <i>J. T. B. Ambler M.D.</i> 22e. ADDRESS <i>Easton, Maryland 21601</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>									
23b. DATE <i>11-19-68</i>									
23c. NAME OF CEMETERY OR CREMATORY <i>Union</i>									
23d. LOCATION (City or Town) (County) (State) <i>Goldsboro Caroline Md.</i>									
24. FUNERAL DIRECTOR <i>John E. Boulain</i> ADDRESS <i>Dyersburg, Tenn.</i>									
25a. REC'D BY REGISTRAR <i>Charles Judge</i>									
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
DATE <i>NOV 19 1968</i>									



FOR STATE HEALTH DEPT.

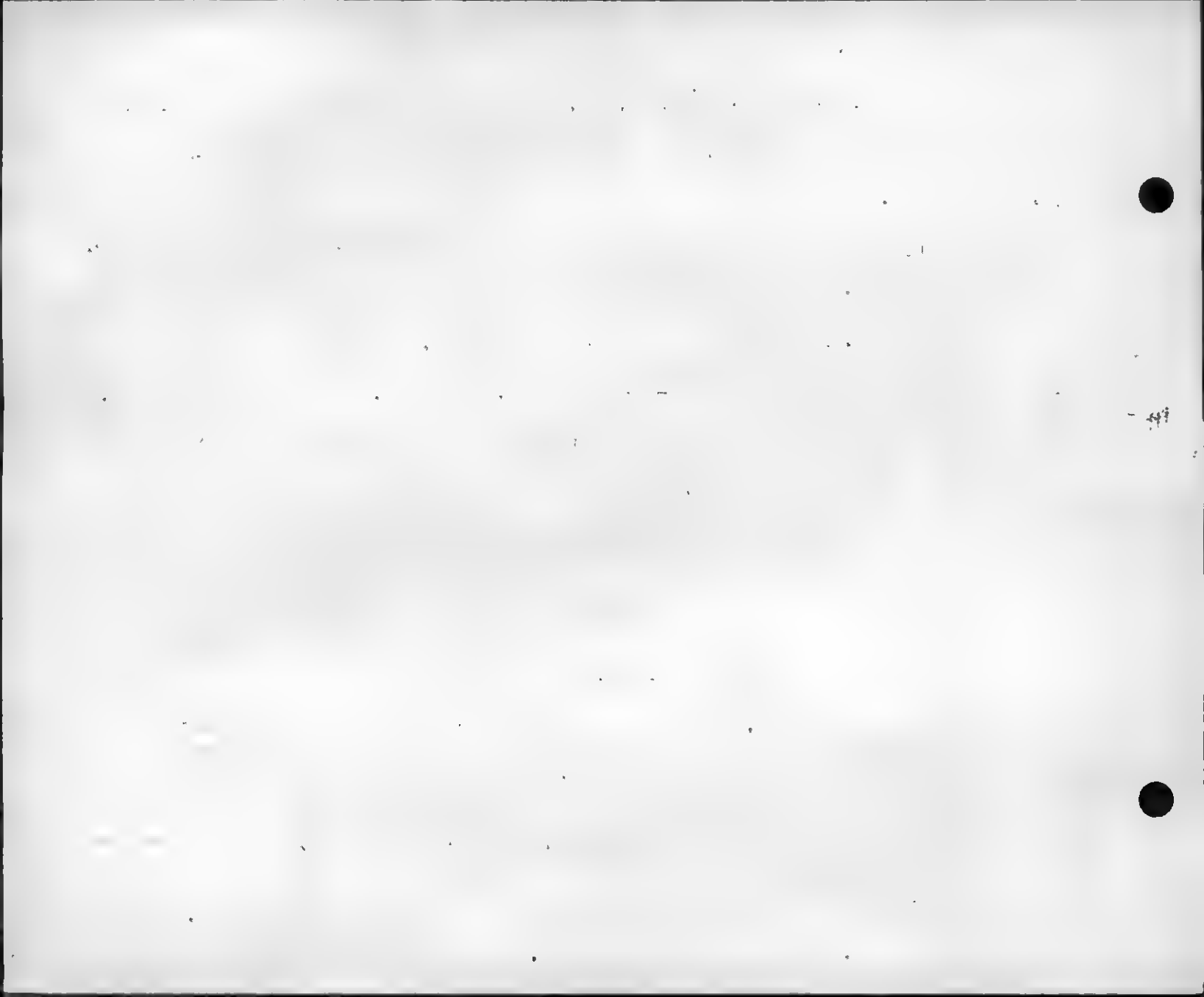
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2 & 9 Film 107
12/3/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16529

1. DECEASED-NAME (Type or Print) <i>Herman Edward Ledrum, Sr.</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11-22-68			2b. HOUR 10 PM		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>7/25/1933</i>	6 AGE (in years last birthday) <i>35</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>11</i> Day <i>22</i> Year <i>19</i>		
7a. BIRTHPLACE (State or foreign country) <i>Id.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Talbot</i>		
10 CITY OR TOWN OF DEATH <i>NRTILGHMAN</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Cheer, operator Seafood Co.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Id.</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Tilghman</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <i>Daniel E. Ledrum</i>			15 MOTHER'S MAIDEN NAME <i>Mary A. Ferguson</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		
16b. SOCIAL SECURITY NO. <i>214-30-8552</i>			17. INFORMANT <i>Mrs. Herman E. Ledrum, Tilghman, Md.</i>			ADDRESS		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>EXPOSURE IN WATERS OF CHESAPEAKE BAY</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>BOAT SANK BENEATH THEM</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>69P. M. 11-22-68</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>BOAT SANK</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.) <i>CHES. BAY</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>OFF TILGHMAN TALBOT Md.</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Lewis A. Nulty</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>11-25-68</i>		
EXAMINER'S NAME (Type) <i>WELTY</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>11/25/1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Wesleyan</i>		
24 FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>			23d. LOCATION (City or Town) (County) (State) <i>Tilghman, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>NOV 26 1968</i>		
			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Sister Anita McCarrin</i>			2a. DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1968</i>			2b. HOUR of Day <i>1:30 P</i>							
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/24/89</i>		6. AGE (in years last birthday) <i>78</i> YRS.		7. FUNDER 1 YEAR MONTHS <i>1</i> DAYS <i>1</i>		8. IF UNDER 24 HRS. HOURS <i>1</i> MIN <i>30</i>			
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.							
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>			13b. COUNTY <i>Caroline Ridgely</i>			13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER <i>None</i>		
14. FATHER'S NAME First <i>Daniel</i> Middle <i>McCarrin</i> Last				15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Segan</i> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>St. Benedicts Convent Ridgely, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage</i> <i>431.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>13 Nov</i> , 19 <i>68</i> , to <i>13 Nov</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>13 Nov</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Stephen O. Camp</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>11-13-68</i>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>11-16-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Benedicts</i>			23d. LOCATION (City or Town) (County) (State) <i>Ridgely Caroline Md.</i>				
24. FUNERAL DIRECTOR <i>John E. Boulaia</i>						ADDRESS <i>Guernsey</i>			25a. REC'D BY REGISTRAR DATE <i>NOV 15 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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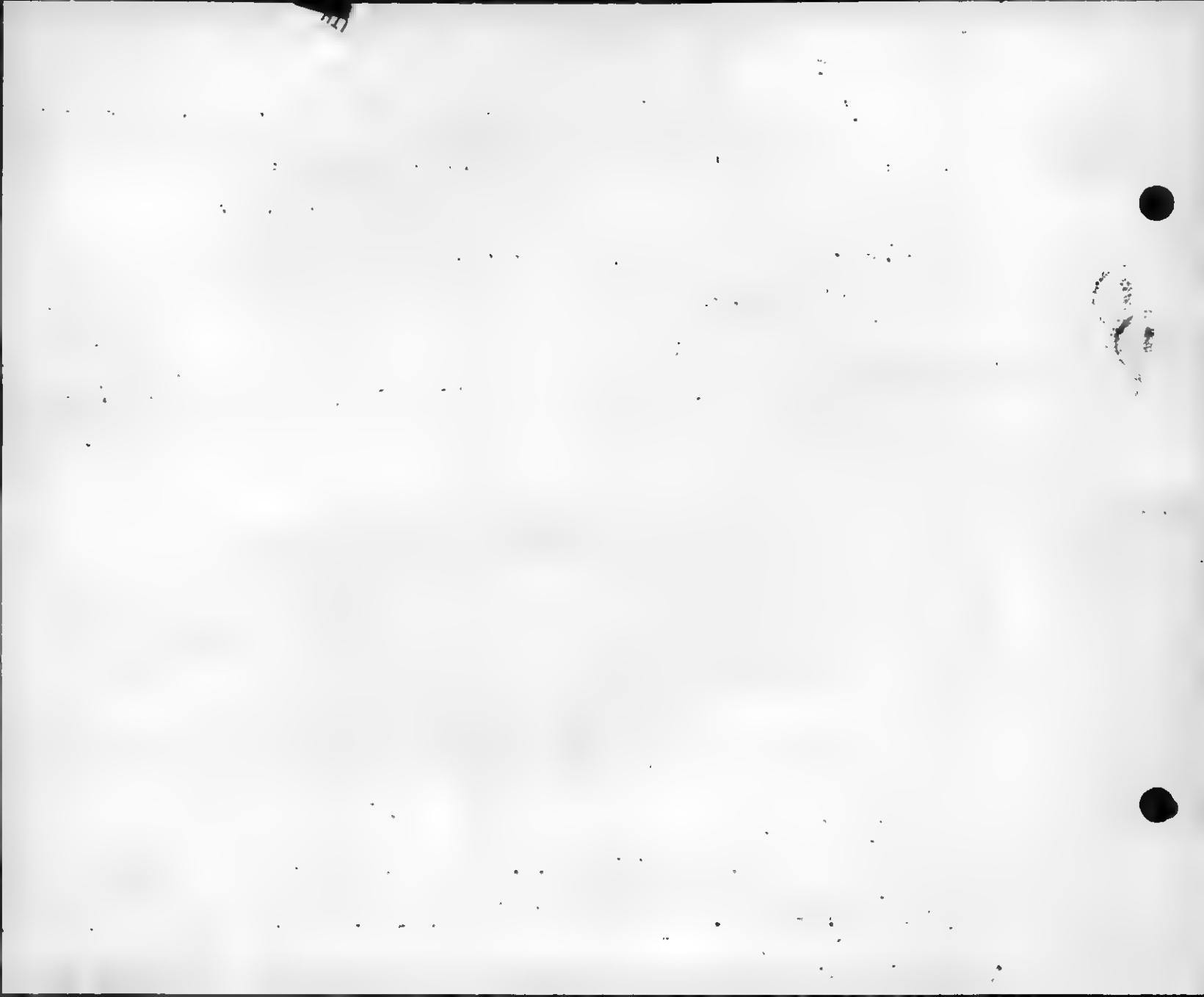
1

10527

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10541

1 DECEASED-NAME (Type or print) JENNIE Scott MOORE			2a. DATE OF DEATH Month 11 Day -25 Year 68			2b. HOUR 3:30 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH November 4, 1883		6 AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wife		12b. KIND OF BUSINESS OR INDUSTRY House	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centerville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 223 N. CONOVERS ST.		14 FATHER'S NAME First Middle Last Scott - Phillips		15 MOTHER'S MAIDEN NAME First Middle Last MARY - MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-329372		17 INFORMANT Sister Mrs. Keba Andrew Address 3114 Acton Road Baltimore, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4267 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-23-68	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 531X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (the hospital) attended the deceased from 11-23, 1968 to 11-25, 1968 , that (I) (we) last saw the deceased alive on 11-25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Carney DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11-25-68			
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney		22e. ADDRESS Easton, Maryland 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City or Town) (County) (State) Centerville, Q.A. Co. Md.	
24. FUNERAL DIRECTOR James H. Barber		25a. RECEIVED BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1654

16528

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Williams</i>		First <i>H.</i>	Middle <i>Paxson</i>	Last	2a. DATE OF DEATH Month <i>11</i> Day <i>10</i> Year <i>1968</i>		2b. HOUR <i>8-25</i> AM	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>1-9-1884</i>			6. AGE (in years last birthday) <i>84</i> YRS.	IF UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>10</i>		IF UNDER 24 HRS HOURS <i>8</i> MIN <i>25</i>
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>		Md.		
1d. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Biologist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Goldsboro</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>None</i>		
14. FATHER'S NAME First <i>Eugene</i> Middle <i>Paxson</i> Last		15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>Livesy</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>184-05-9175A</i>		17. INFORMANT <i>Josephine Paxson</i>		Address <i>Goldsboro, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>< 4 days</i> <i>1943</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i> <i>None</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>11-10</i> , 19 <i>68</i> , to <i>11-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>				22c. DATE SIGNED <i>11-10-68</i>		22d. PHYSICIAN'S NAME (Type)		
22e. ADDRESS								
23a. B. J. RIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11-13-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Greensboro, Caroline Md</i>		
24. FUNERAL DIRECTOR <i>John E. Bowles</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
25c. ADDRESS <i>Greensboro, Md</i>				25d. DATE <i>NOV 13 1968</i>				



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VR A15
304A REV

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16529										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last EDWARD ALFRED SMITH			2a DATE OF DEATH Month Day Year November 22 1968		2b HOUR 5:37 PM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 29, 1906		6 AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT Md				
10 CITY OR TOWN OF DEATH Easton			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Easton Memorial Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman		12b KIND OF BUSINESS OR INDUSTRY Power & Light Co.		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Caroline		13c CITY OR TOWN Denton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 113 S. First Street	
14 FATHER'S NAME First Middle Last Alfred Marion Smith			15 MOTHER'S MAIDEN NAME First Middle Last Annie Reta Tilghman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown No			16b SOCIAL SECURITY NO. 214-07-7565		17 INFORMANT Address Mrs. Sue A. Smith (Wife) Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About An Hour</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/18/68</u> , 19 <u>68</u> , to <u>11/22</u> , 19 <u>68</u> , that (II) (we) last saw the deceased alive on <u>11/22/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Dr. Philip Felipe</u> MD DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED November <u>26</u> /1968		
22d PHYSICIAN'S NAME (Type) Dr. Philip Felipe				22e ADDRESS 103 Gay Street, Denton, Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov. 26, 1968		23c NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24 FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a REC'D BY REGISTRAR DATE DEC 2 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

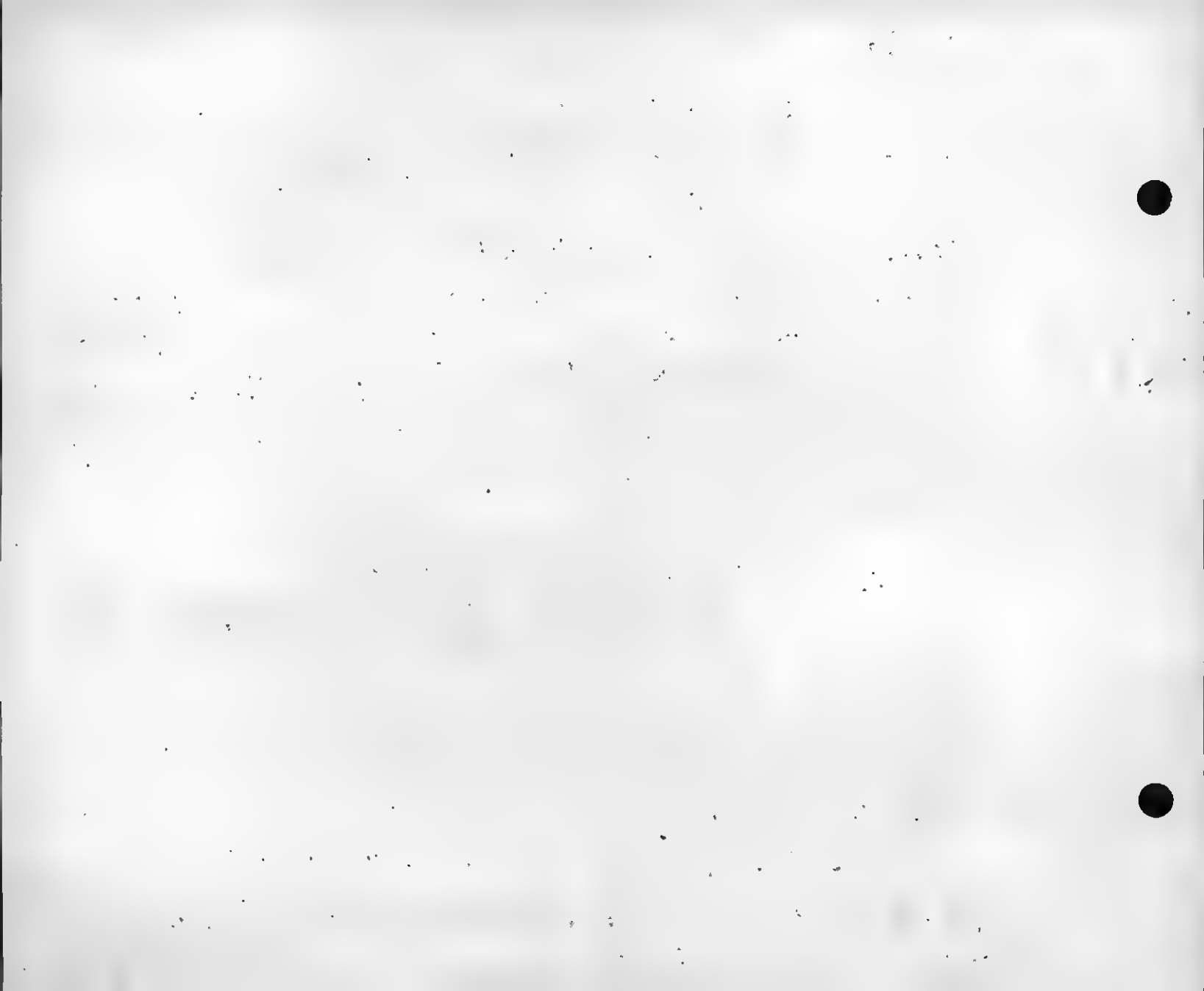


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VR A15 (4)
30M REV. 1/68

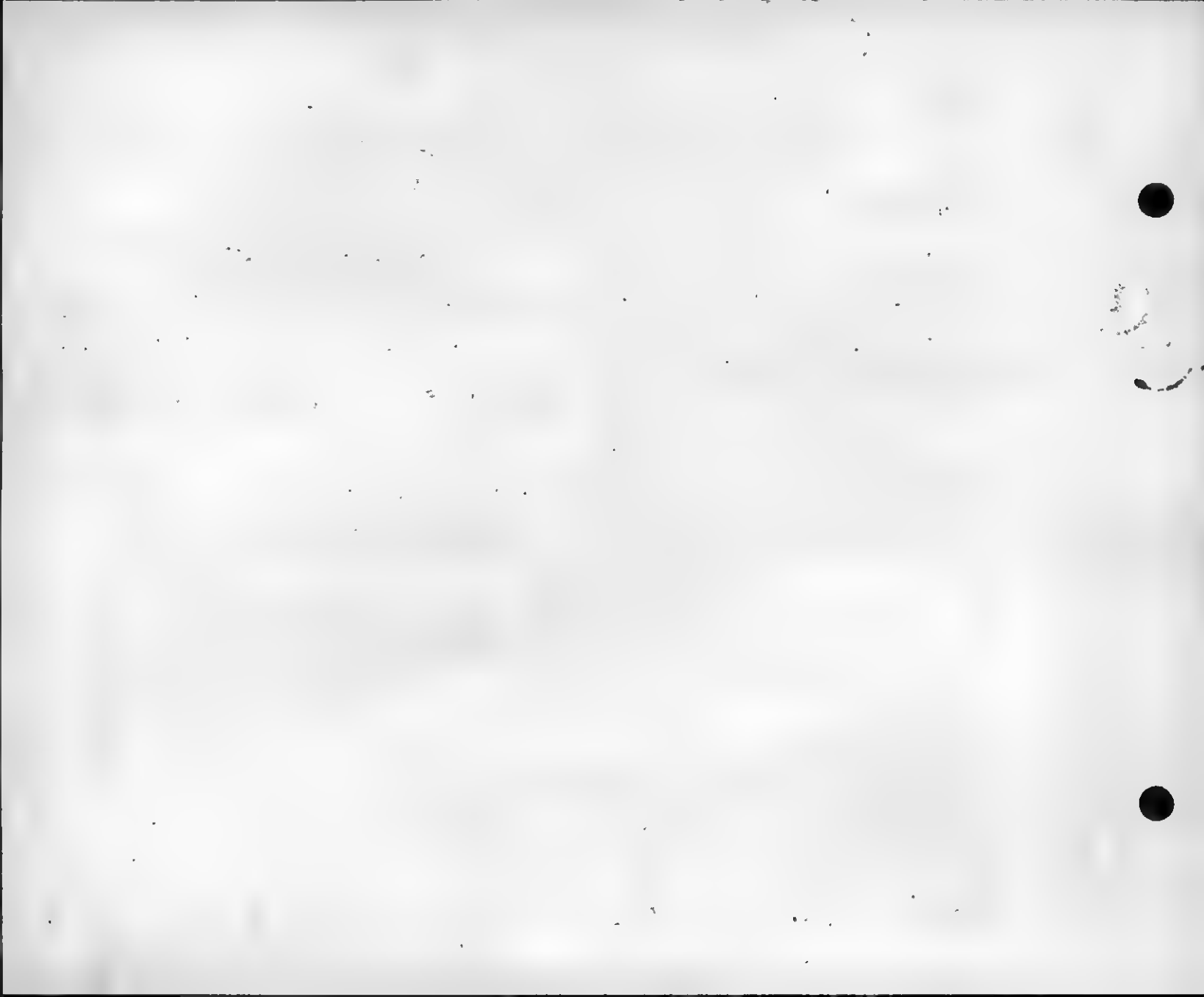
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <i>Patrick Douglas Starkey</i>			First Middle Last			2a. DATE OF DEATH Month <i>11</i> Day <i>23</i> Year <i>1968</i>			2b. HOUR <i>2:40 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>November 21, 1968</i>			6. AGE (In years lost birthday) YRS MONTHS DAYS <i>2 2 2</i>		7. UNDER 1 YEAR MONTHS DAYS <i>2</i>		IF UNDER 24 HRS HOURS MIN <i>40</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md						
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>			13b. COUNTY <i>Kent</i>			13c. CITY OR TOWN <i>Chestertown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>317 College Ave</i>		
14. FATHER'S NAME First Middle Last <i>Philip DENNIS STARKEY</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Vicki Jo TURNER</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>NONE</i>			17. INFORMANT <i>Father</i> Address <i>Philip DENNIS STARKEY, Chestertown, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>PNEUMONIA, ASPIRATION</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ATELECTASIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>DOUBLE FOOTING BREECH</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>DOUBLE FOOTING BREECH</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>11-22</i> , 19 <i>68</i> , to <i>11-23</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-23</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Richard Tyson, M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>11-26-68</i>						
22d. PHYSICIAN'S NAME (Type) <i>RICHARD TYSON</i>						22e. ADDRESS <i>EASTON Md 21601</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>			23b. DATE <i>Nov. 25, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Chestertown Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Centerville P.D. Co. Md.</i>			
24. FUNERAL DIRECTOR <i>James H. Butler Jr. - Butler Bros. Centerville, Md.</i>						25a. RECEIVED BY REGISTRAR DATE <i>DEC 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
ELISABETH						STRAUGHN		11 Month 5 Day 68 Year			3:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE		WHITE		2-11-1880			88 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				TALBOT Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			HOSPITAL IN PLAINS			Retired MILLINER					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			COUNTY			YES		105 South Liberty			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JAMES HENRY STRAUGHN			LAURA - SIMMONS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			220-32-1721			NIEZE Mrs. Robert W. Pratt			303 Northway Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Uremia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) chronic pyelonephritis with											} Uncertain
DUE TO, OR AS A CONSEQUENCE OF											
(c) refractory anemia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-3 1968, to 11-5 1968, that (I) (we) last saw the deceased alive on 11-2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
Robert W. Trever								11-7-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						RD3 Easton, Md. 21601					
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Nov. 8, 1968		Chesterfield Cemetery		Centerville P.A. Co.		Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James H. Barton Jr.				1301 Barton St. Centerville, Md.		NOV 12 1968		Charles Judge			



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16532

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16546

1. DECEASED-NAME (Type or print) <i>George Alvin Whitely</i>			2a. DATE OF DEATH Month <i>11</i> Day <i>16</i> Year <i>68</i>			2b. HOUR <i>11</i> AM		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>FEB. 22 - 1902</i>			6. AGE (In years last birthday) <i>66</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>CHESTERTOWN, MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TA/160T</i> Md.		
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp. 1</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>WATERMAN</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i> COUNTY <i>QUEEN ANNE</i>		13b. CITY OR TOWN <i>GRASONVILLE</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>XX</i>		
14. FATHER'S NAME First <i>FRANK</i> Middle <i>WHITELY</i> Last <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last <i>UNKNOWN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>218-01-7555</i>		17. INFORMANT <i>MRS. JEANNETTE WHITELY</i> Address <i>243 BLAKENY BALT. 38</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerotic heart</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>dissect</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> (?)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>16 Nov 68</i> , 19 <i>68</i> , to <i>16 Nov 68</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>16 Nov 68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Thomas Harrison MD.</i>		DEGREE <i>MD.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>17 Nov 68</i>		
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22e. ADDRESS <i>Easton Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>ANATOMY BOARD NOV. 18</i>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE MD.</i>		
24. FUNERAL DIRECTOR <i>Edgar L. Lane Church Hill Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>DATE NOV 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>		

(M)



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Oma			First Dieffenderfer Middle Willson Last			2a. DATE OF DEATH Month 11 Day 7 Year 68		2b. HOUR 10 A M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/31/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RD # 2	
14. FATHER'S NAME First NATHAN Middle Dieffenderfer Last			15. MOTHER'S MAIDEN NAME First EMMA Middle BURKE Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 316-54-9380		17. INFORMANT Address MRS. EMILY MIELKE, EASTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. YRS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Vascular Thrombosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Nov 2, 1968 , to Nov. 7, 1968 , that (I) (we) last saw the deceased alive on Nov. 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. KRECET JR.		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/7/68				
22d. PHYSICIAN'S NAME (Type) S. KRECET JR.		22e. ADDRESS EASTON, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/9/1968		23c. NAME OF CEMETERY OR CREMATORY THIRD HAVEN		23d. LOCATION (City or Town) (County) (State) EASTON, MD				
24. FUNERAL DIRECTOR Marion E. Newnam & Son		ADDRESS EASTON, MD		25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

